MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since January 27 1947
Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since January 27 1947

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 425 Fiermans ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Michael Albione (MICHAEL ALBIONE)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 16, 1911

8. AGE: Years 35 | Months 3 | Days 13 | If less than one day hrs. min.

9. Birthplace Italy (Town, county, and state)
10. Usual occupation Barber
11. Industry or business

MOTHER FATHER
12. Name Vincent Albione
13. Birthplace Italy
14. Maiden name Guiseppetta Lombardo
15. Birthplace Italy

16. Informant Personal History- Hospital Records
Address Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/1/47 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Baltimore
18. Funeral director Leonard J. Kuck
Address 530 Harford Road

19. 1/30 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1947 at 7:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27 1947 to January 29 1947 and that I last saw h alive on January 29 1947

	DURATION
Immediate cause of death Pulmonary Tuberculosis	Since November 1930
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W C Bridges M. D. or other
Address Towson 4, Maryland Date signed 1-29-47

Evidence for the addition of date of burial is shown on G108 2/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Box)

00182

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:
County Balto
City or town Baltimore 21, md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years.
Hospital, institution, or street address where death occurred:
65 Edgewater apartments
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Baltimore
City or town Baltimore 21, md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 65 Edgewater apt
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Annie Laurie Allee.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife none
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 11 July 1864

8. AGE: Years	Months	Days	If less than one day
82	6	5	... hrs. ... min.

9. Birthplace Kingston Hall, Maryland.
(Town, county, and state)
10. Usual occupation retired
11. Industry or business
FATHER 12. Name James Daniel Henry Dennis
13. Birthplace Pittsville, md.
MOTHER 14. Maiden name Mary Ellen Parlow
15. Birthplace Pittsville, md.
16. Informant Mrs. Hulbert Philips
Address 65 Edgewater apartments
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/10/47 (month) (day) (year)
Cemetery or crematory Salisbury, md - Parsons Cemetery
Location " Co. "
18. Funeral director Walter Holloway.
Address Salisbury, md.
19. Jan. 8 (Date rec'd by registrar) 19 47 John R. Cruell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 January 1947, at 4:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 January 1947, to 8 January 1947 and that I last saw h.. alive on 7 January 1947

	DURATION
Immediate cause of death Hypostatic pneumonia	36 hrs.
Due to Senile debility	
and Toxemia	
Due to recent fracture of left radius & radius - Secured	
Other conditions Accidental fall. 5 Jan 47 C.W.&R.	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

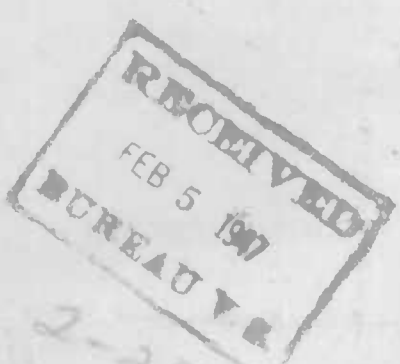
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of January 5, 1947
Where did injury occur? 65 Edgewater Apts. (City or town) Baltimore 21, (County) Maryland (State)
Injured at home, farm, industry, public place (where?) in her home.
Means of injury accidental fall. Injured at work?

23. SIGNATURE John R. Funk M. D. or other
Address 901 Fawnbrae Ave Baltimore, md Date signed 8 Jan 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING



2-35

2-0440

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00183

932

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:
County Baltimore
City or town Parkton, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Parkton R F D
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lillie Blanche Almony

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife Benj H. Almony
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 1 - 1873

8. AGE: Years	Months	Days	If less than one day
73	10	6	..... hrs. ..... min.

9. Birthplace Harford Co. Md
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name Thomas Norris
13. Birthplace Harford Co. Md

MOTHER
14. Maiden name Mary Catherine Agnew
15. Birthplace Harford Co. Md

16. Informant Miss Mary Almony
Address Parkton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 19-1947 (month) (day) (year)
Cemetery or crematory McKendree
Location White Hall R.F.D.
18. Funeral director Howard S. Mankins
Address White Hall Md

19. Jan. 18 1947 (Date rec'd by registrar) Mrs Howard S. Mankins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1947, at 6 30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1941 to Jan. 17 1947 and that I last saw h.. alive on Jan. 16 1947

Immediate cause of death Chronic myocarditis — DURATION

Due to

Due to

Other conditions Hypertension generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. W. France M. D. or other
Address Parkton, Md Date signed 1/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00184

8

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 217 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 217 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 419 Hazlett Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: GEORGE L. ANDERSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1-8-95

8. AGE: Years	Months	Days	If less than one day
52	0	8	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business:

FATHER
12. Name: George Anderson
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: ? Silright
15. Birthplace: West Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan-20-1947 (month) (day) (year)

Cemetery or crematory: Lorraine Baltimore National

Location: Baltimore Md.

18. Funeral director: Ellsworth Armacost

Address: 3911 Liberty Heights Ave.

19. Jan. 17 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16, 1947 at 4:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13, 1946 to January 16, 1947 and that I last saw him alive on January 16, 1947

Immediate cause of death: DILATATION AND HYPERTROPHY OF THE RIGHT VENTRICLE WITH HEART FAILURE — DURATION: 7 months

Due to: Bronchiectasis associated with Fibrosis and Cavity Formation of — DURATION:

Due to: left Lung — DURATION: 7 months

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles Gallion M.D. (M. D. or other)

Address: V. A. Ft. Howard, Md. Date signed: 1/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for the change of date of birth is shown on G 108 1/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

50

00185

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto
City or town Sparrows Point
(If outside city or towo limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1416 F St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Baker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife Otto Baker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 5 1881

8. AGE:

Years	Months	Days	If less than one day
65	1	11	..... hrs. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Henry Pappenheimer

13. Birthplace Germany

MOTHER 14. Maiden name Dora Kuhn

15. Birthplace

16. Informant Mrs. Otto Baker

Address 416 F St.

17. Removal Date thereof Jan 18/47
(Burial, cremation, or removal. Which?) (month) (day) (yenr)

Cemetery or crematory Oberlin

Location Steuart Pa

18. Funeral director Ulbrich Funeral Home

Address 7008 Orleans St.

19. 1/18 1947 A.W. Ulbrich
(Date rec'd by registrar) ams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1947, at 12 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 46, 1946, to Jan 16 1947
and that I last saw h... alive on Jan 16, 1947

Immediate cause of death Carcinoma of the breast

DURATION: 6 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eugene F Neary M.D.
M. D. or other

Address 7001 Wyoming Ave Date signed 1-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d ★ 00186

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:
525 E. Joppa Road

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No. 525 E. Joppa Road
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Rachael Kate Bayne

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John Talbott Bayne (Deceased)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 20, 1869

8. AGE: Years	Months	Days	If less than one day
77	0	14	..... hrs. ..... min.

9. Birthplace: Alesia Carrol County, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same

FATHER — 12. Name: John L. Nott

FATHER — 13. Birthplace: Westminister, Md.

MOTHER — 14. Maiden name: Rebecca Fowble

MOTHER — 15. Birthplace: Westminister, Md.

16. Informant: John Earl Bayne

Address: Padonia Rd. Padonia, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-5-47 (month) (day) (year)

Cemetery or crematory: Providence Cemetery

Location: Providence, Md.

18. Funeral director: John Burns Sons

Address: York Rd. Towson Md.

19. Jan 4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 January 1947 at 1:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 December 1946 to 3 January 1947 and that I last saw her alive on 2 January 1947

Immediate cause of death	DURATION
Acute Congestive Heart failure	1 week
Due to: Arteriosclerosis	Unkn.
Due to:	
Other conditions: Hypertension Gangrene – Left leg	7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Walter T. Kees M.D.
M. D. or other

Address: Cockeysville, Md. Date signed 3 Jan. 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-380-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d * 00187 R

Reg. Dist. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Fieldstone Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Virginia Grace Beeson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Albert Beeson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 13. 1861

8. AGE: Years	Months	Days	If less than one day
86		10	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:

FATHER 12. Name	Edward Powell
13. Birthplace	N.C.
MOTHER 14. Maiden name	Eleanor Hunt Phelps
15. Birthplace	U.S.

16. Informant: Mrs. Maude L. Wallace
Address: Randallstown Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan 28 1947 (month) (day) (year)
Cemetery or crematory: Garden of Memory
Location: Conley Bro. Funeral
18. Funeral director: J. Wills Lemmon
Address: 510 Liberty Heights Ave.
19. 1/24 1947 (Date rec'd by registrar) D. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 23 1947, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 28th 1946, to Jan. 23rd 1947
and that I last saw her alive on Jan. 22nd 1947

Immediate cause of death	DURATION
Chronic Myocarditis	6 mons
Due to: Coronary sclerosis	3 yrs
Due to: Art. Solerosis	3 yrs
Other conditions: Cerebral Thrombosis (Include pregnancy within 3 months of death)	May 5, 1946

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James A. Miller M.D. (M. D. or other)
Address: Pikesville, Md. Date signed: 1/24/47

STATE OF MARYLAND—CERTIFICATE OF DEATH

94a 00188

1. PLACE OF DEATH

County Balto. Co. Registration Dist. No. 41

Village or City Middle River No. Martins Plant St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where deeth occurred ..... yrs. ..... mos. ..... ds. How long in U.S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Frederic Bishton

(a) Residence: No. 6100 Old Washington St., Blvd Ward. Balto Co

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Helena

6. DATE OF BIRTH (month, day, end year) June 4/1885.

7. AGE Yeers	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61	7	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Inspector

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Martin's Plant

10. Date deceased last worked at this occupation (month end year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) N.Y.

FATHER

13. NAME Frederick Bishton

14. BIRTHPLACE (city or town) (State or country) England

MOTHER

15. MAIDEN NAME Sarah J. Simpson

16. BIRTHPLACE (city or town) (State or country) N.Y.

17. INFORMANT (Address) Personnel Mgr. at Martins c/o Dr. Bowers.

18. ~~BURIAL, CREMATION, OR REMOVAL~~ Place Washington D.C. Date Jan 22, 1947

19 UNDERTAKER (Address) J. William Lee 1300 - 4th St. N.E. D.C.

20. FILED Jan 22, 1947 John S. Connelly Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (Month) Jan (Day) 22, 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1947, to Jan 22, 1947

I last saw him alive on ....., 19..... ; death is said to have occurred on the dete stated above, et ..... m.

The **PRINCIPAL CAUSE OF DEATH** and related ceuses of Importance were as follows:

	Date of onset
Coronary Occlusion	

Other **Contributory Causes** of importance:

Name of operation ..... Dete of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Dete of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury .....

Neture of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) J. J. McLaughlin M.D. M. D.

(Address) Deputy Medical Examiner

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

Kimball. Md.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home.** For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	**The principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		**Other contributory causes of importance:**	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00189

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Stoneleigh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Stoneleigh
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7106 Telford Rd
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME Winfield Scott Block BLACK

3. (b) Social Security Number 212-09-5805?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Florence M. Block
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1884

8. AGE: Years 62 | Months 11 | Days 29 | If less than one day: ....hrs. ....min.

9. Birthplace: Bristol Pennsylvania
(Town, county, and state)

10. Usual occupation: Mechanical Engineer

11. Industry or business: American Sugar Co.

FATHER
12. Name: Samuel W. Bleyle
13. Birthplace: Unknown

MOTHER
14. Maiden name: Susan Rickert
15. Birthplace: Pennsylvania

16. Informant: Mrs. Florence M. Block
Address: 7106 Telford Rd., Stoneleigh Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Jan. 26 1947 (month) (day) (year)

Cemetery or crematory: Bristol, Bristol
Location: Bristol Pa. Bristol, Pa.

18. Funeral director: Wm. J. Tickner & Sons
Address: North & Pa. Aves

19. 1-20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/20/ 1947, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943, to January 20 1947
and that I last saw him alive on January 19 1947

Immediate cause of death: Cerebral Vascular accident — DURATION: 6 mos.
Due to: Arteriosclerosis — unknown
Due to: Hypertension — unknown
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Francis W. Gaut M.D.
M. D. or other
Address: 711 Park ave Date signed: 1/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00190 B

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

I. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Mt. Pleasant Sanatorium

Stay in hospital or inst. (yrs., or mos., or days): 4 years 2 months

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2625 Quantico Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Morris Bond.

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: ROSE

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 15, 1891

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
55	8	28		

9. Birthplace: Lithuania (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business:

FATHER — 12. Name: Chajin Bond

FATHER — 13. Birthplace: Lithuania

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace: Lithuania

16. Informant: Selma Austerlitz (daughter)

Address: 2625 Quantico Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-47 (month) (day) (year)

Cemetery or crematory: Herring Run

Location: Phil. Rd. + Bowleys Lane

18. Funeral director: Jack Lewis Inc

Address: 1439 E. Balto St.

19. 1/14 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13, 19 47, at 11 50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 7, 1946 19 to Jan. 13, 19 47 and that I last saw him alive on Jan. 13, 19 47

Immediate cause of death	DURATION
Myocardial Failure	
Due to Congestive Heart Failure	1 month
Due to Pulmonary Tuberculosis	18 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Albert J. Shuei M.D

M. D. or other

Address: Owsterstown, Md. Date signed: 1/13/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00191

Reg. Dist. No. 321

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 11 mos., 5 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 11 mos., 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3109 Westwood Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mrs. Aide Bonetti

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Robustiano Bonetti

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): May 15, 1898

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
48	7	17		

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Guiseppe Rebecki

13. Birthplace: Italy

MOTHER — 14. Maiden name: Adele Bonele

15. Birthplace: Italy

16. Informant: Mrs. Aide Bonetti

Address: 3109 Westwood Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/4/47 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cemetery

Location: 4430 Belair Rd., Balto., Md.

18. Funeral director: Frank DellaNoce

Address: 322 Trinity St., Balto., Md.

19. Jan. 1, 1947 (Date rec'd by registrar) Earl T. Webster Registrar

Rec'd on 1-4-47 Dr E E nichols nw

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1, 1947, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27, 1946, to January 1, 1947 and that I last saw h... ex... alive on January 1, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 3 Yrs.

Due to: Tubercle Bacilli

Due to:

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: No operation — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. L. Siegel M.D. (M. D. or other)

Address: Mount Wilson, Md. Date signed 1/1/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ing correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2-320- 1-10

Evidence for the change of age is shown on C 108 1/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-1a

CERTIFICATE OF DEATH

00192

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town 7307 Hughes Ave.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Grace Creek
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1317 Forrest Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Henry Harrison Braden

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Sarah Anne Winters
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1st, 1873

8. AGE:	Years	Months	Days	If less than one day
	73	74		hrs. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business Retired
FATHER 12. Name John Braden
13. Birthplace W. Va.
MOTHER 14. Maiden name Unknown
15. Birthplace " "
16. Informant Lawrence Braden
Address 1317 Forrest Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 14-47 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.
18. Funeral director Thos. G. Connelly
Address 418 Eastern Ave. Essex
19. Jan 13. 1947 (Date rec'd by registrar) D. I. Harbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1947, at 8:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1947 to Jan 11 1947 and that I last saw him alive on — 19
Immediate cause of death Coronary Occlusion — DURATION: sudden
Due to Arterio-Sclerosis Generalized — DURATION: two yrs
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dawson L. Harbes M.D. M. D. or C. M.
Address Sparrows Point Md Date signed 1/15/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

00193 P

Reg. Dist. No. 33

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore

City or town: Reisterstown Road Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: West Virginia County: Barbour

City or town: Philippi

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry F. Brittingham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Effie M. Brittingham

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 12-1881

8. AGE:

Years	Months	Days	If less than one day
65	5	—	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Mayor of Philippi W. Va.

11. Industry or business: Retired B. & O. R.R. Station Agent

FATHER 12. Name: George R. Brittingham

13. Birthplace: Maryland

MOTHER 14. Maiden name: Laura V. Melvin

15. Birthplace: Maryland

16. Informant: Mrs. F. P. McCubbin

Address: Owings Mills, Maryland

17. Burial & Burial (Burial, cremation, or removal. Which?) Date thereof: January 13-1947 (month) (day) (year)

Cemetery or crematory

Location: Philippi West Virginia

18. Funeral director: Burgee Funeral Home

Address: 3631 Falls Road

19. 1-13 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12- 1947, at 11:35 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/10/47 19.. to 1/12/47 19..

and that I last saw h/M alive on 1/12/47 19..

Immediate cause of death	DURATION
Myocarditis	4 years
Cardiac decompensation	10 days
Due to Arterio Sclerosis	20 yrs
Due to Pneumonia Bronchial	2 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John L. Kelly M. D. or other

Address: Reisterstown Md Date signed: 1/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00194

126

CERTIFICATE OF DEATH

Reg. Dist. No. 33 a

1. PLACE OF DEATH:
County: Reisterstown
City or town: Balto. Co. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Nannie E. Brooks

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Wm. C. Brooks
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 29 1851

8. AGE: Years	Months	Days	If less than one day
85	1	14	hrs. min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)
10. Usual occupation: Housemaker
11. Industry or business

FATHER
12. Name: Roman Mayes
13. Birthplace: Balto. Co. Md

MOTHER
14. Maiden name: Margaret Ann Mayes (nee Mayer)
15. Birthplace: Balto. Co. Md.

16. Informant (Son) Landon M. Brooks
Address: Sparks, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 15 1947 (month) (day) (year)
Cemetery or crematory: Desoops
Location: Sparks, Maryland

18. Funeral director: Landon M. Brooks
Address: Sparks, Maryland

19. 1-14 19 47 Mary B. Kline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 19 47, at 10 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-6 19 46, to 1-12 19 47
and that I last saw h cd alive on Jan. 12 19 47

Immediate cause of death	DURATION
Cardiac Decompensation	4 da.
Due to: Hypertensive C. V. Disease	7 yrs.
Arteriosclerosis	7 yrs.
Due to: Mitral Insufficiency	7 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. D. Caples, M. D. (M. D. or other)
Address: Reisterstown, Md. Date signed: 1-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00196 8

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Sparrows point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town Sparrows point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 314 D St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Samuel J Bull

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Virginia Bankam
6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) October 1, 1894

8. AGE: Years 52 Months Days If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired Electrician

11. Industry or business

FATHER 12. Name John F. Bull
13. Birthplace Maryland

MOTHER 14. Maiden name unknown
15. Birthplace unknown

16. Informant Mrs Virginia Bull
Address 314 D St. Sparrowspoint

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-14-47 (month) (day) (year)

Cemetery or crematory Oaklawn
Location Eastern Ave

16. Funeral director John F Kenny Inc
Address 715 Bright St.

19. 1-10 19 47 Dittenrich Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7th 19 47 at 10 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 41 to Jan 7, 19 47
and that I last saw h.../...alive on 12-31- 19 47

	DURATION
Immediate cause of death Coronary Thrombosis	5-10 min
Due to Coronary Artery Disease	4-5 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Theodore Cooper M.D
M. D. or other
Address 2201 Eutaw Place Date signed 1/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00197

Reg. Dist. No. 35

1. PLACE OF DEATH:
County Baltimore
City or town White Hall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Baltimore
City or town White Hall. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME CHARLES HENRY BURNS

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Laura V. Burns
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) March 18. 1866

8. AGE: Years	Months	Days	If less than one day
80	9	26	hrs. min.

9. Birthplace White Hall. Md
(Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business

FATHER
12. Name John Wesley Burns
13. Birthplace White Hall. Md

MOTHER
14. Maiden name Eliza Cooper
15. Birthplace Parkton. Md

16. Informant C. Clifton Burns
Address White Hall. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 16-1947 (month) (day) (year)
Cemetery or crematory Woodlawn
Location White Hall. Md
18. Funeral director Howard S. Markline
Address White Hall. Md

19. Jan. 15, 1947 (Date rec'd by registrar) Mrs. Howard S. Markline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1947, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938, to Jan 14 1947
and that I last saw h[illegible] alive on Jan 13 1947

Immediate cause of death Carcinoma of liver — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE A. M. France M. D. or other
Address Parkton, Md. Date signed 1/15/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157 — 00195 — Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Balto Co.
City or town: Fork
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Glenarm
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Burns Roy Nancy Anne

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1947

8. AGE: Years | Months | Days | If less than one day ..... hrs. 20 min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name Roy S. Burns
13. Birthplace Virginia

MOTHER — 14. Maiden name Edna G. Burns
15. Birthplace Virginia

16. Informant Roy S. Burns
Address Glenarm

17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan 15 1947 (month) (day) (year)
Cemetery or crematory Fork M. E. Cem
Location Fork Md.

18. Funeral director Clarence E. Arthur
Address Fork Md.

19. Jan 14 1947 (Date rec'd by registrar) C. E. Arthur Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1947, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 13 1947 to — 19..; and that I last saw h... alive on Jan 13, 1947

Immediate cause of death	DURATION
Congenital Malformation —	
Due to Atrophy of the Heart	30 MIN.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford T. Knudson, M.D.
M. D. or other
Address Fork Md. Date signed 1/15/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

00198

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 9 Woodlawn Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Woodlawn

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret D. Calhoun

3.(b) Social Security Number

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Wm P. Calhoun

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Dec 9 1905

8. AGE: Years 41 Months 1 Days 10 If less than one day ... hrs. ... min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Wm J. Porter

13. Birthplace Md

MOTHER

14. Maiden name Ada Huppelat

15. Birthplace Md

16. Informant Wm P. Calhoun

Address 9 Woodlawn Ave

17. Cremation Date thereof 1-21-47

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or cremalory Loudon Park

Location Baltimore Md

18. Funeral director George A. Finley

Address Catonsville

19. 1-21- 19 47 H. W. Miller Deputy

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 47 at 6:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...

and that I last saw h... alive on ... 19 ...

Immediate cause of death Coronary Occlusion — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. McKieffer Dep. Med. Exam. Balto. Co.

M. D. or other

Address 1010 Leeds Ave Date signed 1-20-47

VS A15

1-35

STATE OF MARYLAND—CERTIFICATE OF DEATH

93d 00199 8

1. PLACE OF DEATH

County Baltimore Registration Dist. No.

Village or City Baltimore No. 708 Stoneleigh Rd. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME SARAH ELIZABETH CARBACK

(a) Residence: No. 708 Stoneleigh Road St., Ward.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of John T. Carback

6. DATE OF BIRTH (month, day, and year) Jan. 13, 1860

7. AGE Years	Months	Deys	If LESS then 1 dey, hrs. or min.
86	11	24	

OCCUPATION

8. Trede, profession, or perticular kind of work done, es SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked et this occupation (month end year)

11. Totel time (yeers) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

FATHER

13. NAME ? Harb

14. BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

MOTHER

15. MAIDEN NAME Amelia Weiss

16. BIRTHPLACE (city or town) Baltimore, Maryland
(Stete or country)

17. INFORMANT Mrs. Frank Nesbitt
(Address) 708 Stoneleigh Road

18. BURIAL, CREMATIDN, DR REMDVAL
Place Baltimore, Md. Dete 1/9/47, 19

19. UNDERTAKER HENRY SANDER & SONS, INC.
(Address) NORTH AVE. & BROADWAY

20. FILED Jan 8, 19 47 A. W. Hedrick
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 6 (Day) 1947 (Year)

22. I HEREBY CERTIFY, Thet I ettended deceased from July, 1938, to Jan 6, 1947
I last saw h.er alive on Jan 5, 1947; death is said to have occurred on the date stated above, at 6 A.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Arteris-Sclerotic Cardio-vascular disease	Nov. 1946
Other Contributory Causes of importance:	

Name of operetion None Dete of

What test confirmed diagnosis? Was there an autopsy? No

23. If death wes due to external causes (VIDLENCE) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HDME, or in PUBLIC PLACE.

Menner of injury

Neture of injury

24. Wes diseese or injury in eny way related to occupation of deceased? No

If so, specify

(Signed) Charles H. Thien M. D.

(Address) 6701 York Rd Balto 12 Maryland.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46a

00209

Reg. Dist. No. 3 01

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years, 2 months, 12 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 13 years, 2 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Archibald W. Carrick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Alice Carrick

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 14, 1885

8. AGE: Years	Months	Days	If less than one day
61	11	6	hrs. min.

9. Birthplace: Prince George's County, Md. (Town, county, and state)

10. Usual occupation: Waiter (retired)

11. Industry or Business: Waiter

FATHER — 12. Name: Martin V. Carrick

FATHER — 13. Birthplace: Prince George's Co., Md.

MOTHER — 14. Maiden name: Mary C. Dennison

MOTHER — 15. Birthplace: Prince George's Co., Md.

16. Informant: Hospital records

Address: Maryland, Catonsville-28

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 22, 1947 (month) (day) (year)

Cemetery or crematory: Addison Chapel Cemetery

Location: Seat Pleasant, Md.

18. Funeral director: J. F. Lee's Sons Co.

Address: 308 4½ St. N.E. Washington, D.C.

19. 1-22 1947 (Date rec'd by registrar) Harry J. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1947, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 8 1933, to January 20 1947 and that I last saw him alive on January 20 1947

	DURATION
Immediate cause of death: Acute myocardial failure	24 hours
Due to: Carcinoma of the esophagus	5 months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 1-20-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00201

Reg. Dist. No. 4440

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2621 Slootfield Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: WALLACE CARROLL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9-28-1883

8. AGE: Years: 63 Months: 3 Days: 25 If less than one day: hrs. min.

9. Birthplace: Annapolis, Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Thomas E. Carroll
13. Birthplace: Annapolis, Maryland

MOTHER
14. Maiden name: Fannie A. Mullen
15. Birthplace: Baltimore, Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 27 1947 (month) (day) (year)

Cemetery or crematory: Annapolis National Cemetery

Location: Annapolis, Maryland

18. Funeral director: E. Willis Lamoreau

Address: 1003 W. Balto. St. Balto., Md.

19. 1/24 19 47 (Date rec'd by registrar) H. W. Fedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 19 47 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 19 19 47 to January 23 19 47 and that I last saw him alive on January 23 19 47

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	3 weeks plus
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. C. Neuman, O.D. M.D. M. D. or other

Address: V.A.H. Fort Howard, Md. Date signed: 1/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176a)

CERTIFICATE OF DEATH

00202

Reg. Dist. No. 35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town W. Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Jacksonville, Phoenix
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3. (a) FULL NAME William Royston Carroll

3. (b) Social Security Number 212-28-5151

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) August 9, 1927

8. AGE: Years 19 | Months 5 | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace Jacksonville Balto Co. Md.
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Store

FATHER
12. Name Miles R. Carroll
13. Birthplace Jacksonville, Md.

MOTHER
14. Maiden name Mary A. Shelley
15. Birthplace Monkton, Md.

16. Informant Miles R. Carroll
Address Phoenix, Md.

17. Burial, cremation, or removal. Which?) Burial Date thereof 1 14 47 (month) (day) (year)
Cemetery or crematory Chestnut Grove
Location Phoenix, Md.

18. Funeral director J. Scott Brooks
Address 121 Allegheny Ave, Towson

19. (Date rec'd by registrar) Jan. 15, 1947 Mrs. Howard S. Markline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 12 1947 at 1 20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw h ... alive on ... 19 ...

Immediate cause of death	DURATION
Multiple Fractures	
Fractured Skull	
Due to ST Truck by TRAIN;	
Due to Accidental, at White Hall, Baltimore	
County, Maryland; At R.R. crossing	
Other conditions C&O R.R.	

(Include pregnancy within 3 months of death)

Major findings of operations NONE
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of January 12, 1947.
Where did injury occur? White Hall (City or town) Baltimore (County) Maryland (State)
Injured at home, farm, industry, public place (where?) public places
Means of injury Struck by train; Injured at work? Driver of car

23. SIGNATURE R. M. France M. D. or other
Address Perkton, Md Date signed 1/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

469 ★12 00203 R

Reg. Dist. No. 4-2

1. PLACE OF DEATH:
County Baltimore
City or town St Denis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, Institution, or street address where death occurred:
5013 C St
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town St Denis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5013 C St.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME amelia Blanche Chepalo (Chepaitis)

3.(b) Social Security Number 216-10-6719

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femal	white	Married

6.(b) Name of husband or wife William Chepalo
6.(c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) apr 23 1880

8. AGE: Years 61 | Months 9 | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace Wilno Lithuania (Town, county, and state)
10. Usual occupation Taylor
11. Industry or business Ben Cohn
FATHER 12. Name Balachunas
FATHER 13. Birthplace Lithuania
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace Lithuania
18. Informant Mrs Amelia Krasauskis (Daughter)
Address 5013 C. St. St Denis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-29-47 (month) (day) (year)
Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd
18. Funeral director Joseph Kasinskas Inc
Address 604 Washington Blvd
19. 1/27 (Date rec'd by registrar) 1947 D.W. Kendrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1947, at 2 30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946, to Jan 26 1947
and that I last saw h[illegible] alive on Jan 25 1947

Immediate cause of death	DURATION
Carcinoma of Pancreas	6 Mo.
Due to Metastasis to Liver	
Due to Jaundice	2 Mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of head of Pancreas Date of op. Dec 19/46
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE B B Brumbaugh M. D. or other
Address 5609 Main St Elkridge Md Date signed 1/26/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Chepait is

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

922 ★ NC 00204

Reg. Dist. No. 4K0

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Marylamd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? Two Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3726 E. Lombard St.

(If rural, give LOCATION)

2.(a) If veteran, name war World War One

3.(a) FULL NAME

Francisco Chincarini

3.(b) Social Security Number 705-10-9539

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Chincarini (wife)

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 2, 1888

8. AGE:

Years	Months	Days	If less than one day
58	5	29	..... hrs. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual occupation Track Foreman

11. Industry or business Bethlehem Steel Co.

FATHER 12. Name Francisco Chincarini

13. Birthplace Italy

MOTHER 14. Maiden name ~~Domenica~~ xxxxxxxx Domenica

15. Birthplace Italy

16. Informant Clinical Records, Vets. Adm. Hosp

Address Fort Howard, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 4th 1947 (month) (day) (year)

Cemetery or crematory National Cemetery, Baltimore, Md.

Location Baltimore, Maryland

18. Funeral director Frank Della Noce

Address 322 S. High St. Baltimore, Md.

19. 1-3 47 (Date rec'd by registrar) 19 ..... Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1, 1947 at 1:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30, 1946 to January 1, 1947 and that I last saw him alive on January 1, 1947

Immediate cause of death	DURATION
MESENTERIC THROMBOSIS	3 days
Due to Arteriosclerotic Valvular Heart Disease	14 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Morris E. Kruckoff M.D.

M. D. or Other

Address V. A. FT. HOWARD, MD. Date signed 1/1/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

926 — 00205 — Reg. Dist. No. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Days

Hospital, institution, or street address where death occurred: Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 11 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5105 Bellville Ave.,

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: ALFRED V. COLLISON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ~~////~~ Coretta Collison

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): 4-17-1895

8. AGE: Years	Months	Days	If less than one day
51	8	23	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Vets. Adm. Dept. of Maryland Employment

11. Industry or business: U. S. Government

FATHER

12. Name: Henry Collison

13. Birthplace: Maryland

MOTHER

14. Maiden name: Amanda Houck

15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/13/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cem

Location: Fredk Ave - Balto Md

18. Funeral director: E. Walter Lumpkin

Address: 40 10 Liberty Hgts Ave

19. Jan 10 - 1947 (Date rec'd by registrar) Dawson L. Farby Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10, 1947 at 6:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30, 1946, to Jan. 10, 1947 and that I last saw him alive on January 10, 1947

Immediate cause of death	DURATION
DISEASE OF THE HEART	1 Yr.
Cause: Rheumatism	plus
Due to: Structural lesion, Valvular damage	
Due to: Aortic and Mitral valves, Mitral Stenosis and Insufficiency, Aortic stenosis and Insufficiency and cardiac enlargement	
Due to: Manif: Auricular fibrillation with myocardial insufficiency	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN. DIR.

Address: V.A. FT. HOWARD, MD. Date signed 1-10-47

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 002034

1. PLACE OF DEATH:
County Baltimore
City or town Hampstead (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Hampstead (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel Wesley Cooper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M.

6.(b) Name of ~~husband~~ or wife Kate M Cooper
6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Apr 5 - 1873

8. AGE: Years 73 | Months 8 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Produce Dealer

11. Industry or business

FATHER 12. Name Henry Cooper
13. Birthplace Maryland

MOTHER 14. Maiden name Diane Kemp
15. Birthplace Maryland

16. Informant Mrs J W Cooper
Address Hampstead Md

17. [redacted] Date thereof 1-4
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grace
Location Bolton Co.

18. Funeral director Edw C Tipton
Address Hampstead Md.

19. 47 Jan 3 1947 Cyril E. Frock M.D. Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1947, at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1937, to Jan 1 1947 and that I last saw h... alive on Dec 31 1946

Immediate cause of death	DURATION
Coronary Sclerosis	10 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W C Cutsail M. D. or other
Address Hampstead Md. Date signed 1-3-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00207

Reg. Dist. No. 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Baltimore
City or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yrs.
Hospital, institution, or street address where death occurred:
1334 Poplar Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1334 Poplar Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME George Carroll Corkrin

3.(b) Social Security Number 212-07-6112

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Catherine L. Corkrin
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) July 16, 1877

8. AGE: Years	Months	Days	If less than one day
69	6	7	..... hrs. ..... min.

9. Birthplace St. Anne Arundel County, Md.
(Town, county, and state)
10. Usual occupation Electrician
11. Industry or business Retired
FATHER 12. Name James R. Corkrin
13. Birthplace Maryland
MOTHER 14. Maiden name Sarah Cochran
15. Birthplace Maryland
16. Informant Catherine L. Corkrin
Address 1334 Poplar Avenue
17. Burial Date thereof 1-27-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Loudon Park
Location Baltimore Maryland
18. Funeral director George L. Eckhardt
Address 2101 Frederick Ave. Balto. Md.
19. Jan 24 1947 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23, 1947, at 9:10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to JAN 23 1947
and that I last saw him alive on JAN 22 1947

Immediate cause of death	DURATION
Heart Failure	4 mos
Cardiac Embarrassement	13 yrs.
Due to Arteriosclerotic Heart disease	13 yrs
Due to	
Other conditions Pulmonary Edema	5 days.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J Earl Pass M.D.
M. D. or other
Address 4001 Wilkens Ave Date signed 1-23-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

562

00208

Reg. Dist. No. 44

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 35 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4112 Newbern Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME

NORMAN L. CORSON

3.(b) Social Security Number

705-05-5083

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Unknown

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7-20-1896

8. AGE: Years	Months	Days	If less than one day
50	4	4	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Train Service Man

11. Industry or business: Railroad

FATHER

12. Name: William Corson

13. Birthplace: New Jersey

MOTHER

14. Maiden name: Catherine Simonaire

15. Birthplace: Baltimore, Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 27-47 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location:

18. Funeral director: Charles P Towell

Address: 2427 Edmondson Ave

19. 1/25 (Date rec'd by registrar) 19 47 D. G. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24, 1947 at 2:55a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 20, 1946 to January 24, 1947

and that I last saw him alive on January 24, 1947

Immediate cause of death: CORTICAL ADENOMA OF THE ADRENAL GLAND, RIGHT — DURATION: Unknown

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN. DIR.

Address: V. A. Ft. Howard, Md. Date signed: 1-24-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

00209

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 99 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 99 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 16 A Post Road

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: LAWRENCE E. CRAIN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7-4-1895

8. AGE:

Years	Months	Days	If less than one day
51	4	19	..... hrs. ..... min.

9. Birthplace: Bellefonte, Pa. (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER

12. Name: Edward Crain

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Rhoda Ginsallus

15. Birthplace: Pennsylvania

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?), Date thereof: Jan 27 47 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore Maryland

18. Funeral director: Ellsworth Armacost

Address: 3911 Liberty Heights Ave

19. 1-27 1947 (Date rec'd by registrar) A. W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23, 1947 at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 16, 1946, to January 23, 1947 and that I last saw him alive on January 23, 1947

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic, active, far advanced	13 weeks plus
Due to	
Due to	
Other conditions: Tuberculous laryngitis	13 weeks plus

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLINICAL DIRECTOR

Address: V.A., Ft. Howard, Md. Date signed: 1-28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00210

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Mrs Keller Rest Home. 5501 Edmondson Ave
How long in hospital or institution? 2 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County B Co
City or town HALETHROPE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4318 RIDGE AV.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Annie Cronan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 17 - 1864

8. AGE: Years	Months	Days	If less than one day
82	11		..... hrs. ..... min.

9. Birthplace Ballto. Md (Town, county, and state)
10. Usual occupation Straw Hat worker
11. Industry or business Grey " " Shop
FATHER 12. Name Patrick Cronan
13. Birthplace Ireland
MOTHER 14. Maiden name Eliza Cronan
15. Birthplace
16. Informant Mrs Agnes Myers
Address 4609 Roly Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 4-47 (month) (day) (year)
Cemetery or crematory New Cathedral Cem.
Location Frederick Rd
18. Funeral director John R. Penny
Address 1242 Leds Ave
19. 2-3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1947 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to Jan 31 1947 and that I last saw h.er alive on Jan 31 1947

Immediate cause of death	DURATION
Chr Myocarditis	1 yr
Due to: Cerebral Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE James Stowell M. D. or other
Address Catonsville Date signed 2-3

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

772 00211

Reg. Dist. No. 42

1. PLACE OF DEATH:
County Balto
City or town Relay Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred Gundry San.
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County
City or town Balto (If outside city or town limits, write RURAL and give nearest town)
Street No. 1016 W 36th St. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William L. Crook
3. (b) Social Security Number

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Esther
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.) 3/15/1895
8. AGE: Years 51 Months 10 Days 5 If less than one day ...... hrs. ...... min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name James H. Crook
13. Birthplace Balto
MOTHER 14. Maiden name Ann Cawley
15. Birthplace Balto
16. Informant Mrs. J. Hagner
Address 507 Chumleigh Road
17. Burial (Burial, cremation, or removal (Which?)) Date thereof Jan 23 1947 (month) (day) (year)
Cemetery or crematory Cathedral
Location Old Frederick Road
18. Funeral director J. J. Fahey & Sons
Address 1818 Wright St.
19. 1/22 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1947 at 2:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18 1947, to January 21 1947
and that I last saw him alive on January 20 1947

	DURATION
Immediate cause of death Cardiac Failure	24 hrs.
Due to Tachycardia	50 hrs.
Due to Acute / Chronic } Alcoholism	(?)
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...... Date of op. ......
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ...... Date of ......
Where did injury occur? ...... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ...... Injured at work?

23. SIGNATURE Edgar P. Williamson II M.D. M. D. or other
Address 3325 Frederick Ave (29) Date signed 1/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g ★ 00212 C

Reg. Dist. No. 420

1. PLACE OF DEATH:
County: Baltimore
City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
5117 Rolling Rd.
How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County Baltimore
City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5117 Rolling Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: ELISABETH CROSBIE

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: Howard H. Crosbie
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Sept 17 - 1880

8. AGE: Years 66 | Months 3 | Days 17 | If less than one day: ...hrs. ...min.

9. Birthplace: England (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Housewife

FATHER
12. Name: John Shaw
13. Birthplace: Scotland

MOTHER
14. Maiden name: Anne Kettle
15. Birthplace: England

16. Informant: Mrs H. H. Crosbie
Address: 5117 Rolling Rd, Relay 27, Md

17. burial (Burial, cremation, or removal. Which?) Date thereof 1/6/47 (month) (day) (year)
Cemetery or crematory: Meadowridge Cem.
Location: Howard Co., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: BALTO., MD

19. Jan. 4 1947 (Date rec'd by registrar) A. W. Hedrich Registrar
1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 3, 1947, at 3:45 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1946, to Jan 3 1947
and that I last saw h.e.r. alive on Jan 2 1947

	DURATION
Immediate cause of death: Carcinoma of Pancreas	6 Mo
Due to: General carcinomatosis	2 mo
Due to: Myocardial failure	
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B B Brumbaugh M.D., or other
Address: Elkridge Md. Date signed 1/3/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00213

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County 3 Osborne Ave

City or town Catonsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Osborne ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Katherine S. Cunningham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1856

8. AGE: Years 85 Months 7 Days 8 If less than one day hrs. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Solomon G. Cunningham

13. Birthplace Mayfield Kentucky

MOTHER 14. Maiden name Mary C. Buckner

15. Birthplace Front Royal Va.

16. Informant Mrs. Estelle A. Darby

Address 3 Osborne Ave Catonsville Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb 3 1947 (month) (day) (year)

Cemetery or ~~crematory~~ Prospect

Location Front Royal Va.

18. Funeral director Henry N. Jenkins Funeral Co

Address McCulloh & Orchard Sts.

19. 2/1/47 (Date rec'd by registrar) 19 AW Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31 1947, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1937, to Jan 31 1947

and that I last saw h alive on Jan 31 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr
Due to Arterio-Sclerosis	Treated
Due to Hypertension	5
Due to Myocarditis	5
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W H Woody M. D. or other

Address 1403 Park Ave Date signed 2/1/47

Reed VS
2/1/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00214

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Baltimore

City or town: Carney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

2808 E. Joppa Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Carney

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2808 E. Joppa Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: WILLIAM H. DE BAUGH

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: -----

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 24th, 1856

8. AGE: Years	Months	Days	If less than one day
90	3	2	hrs. min.

9. Birthplace: retired (Town, county, and state)

10. Usual occupation: farmer

11. Industry or business

FATHER — 12. Name: Augustus DeBaugh

13. Birthplace: Germany

MOTHER — 14. Maiden name: Eva Ewing

15. Birthplace: Maryland

16. Informant: Mrs. Emma DeBaugh

Address: 2808 E. Joppa Road

17. burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 28, 1947 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Balto., Md.

18. Funeral director: Lasonby Funeral Home

Address: 7401 Belair Road

19. (Date rec'd by registrar) 19 47 A. M. Bass Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26th, 19 47, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 24 19 47 to Jan. 25 19 47 and that I last saw h alive on Jan. 25, 19 47

Immediate cause of death	DURATION
Coronary Occlusion	2 days.
Due to Arterio Sclerosis	yrs.
Due to & Hypertension	yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major fiodiogs of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas. Green M.D. M. D. or other

Address: Denton - 4 - Md. Date signed: 1/26/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00215

Reg. Dist. No. 42

1. PLACE OF DEATH:
County BALTIMORE
City or town RELAY
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? LIFE
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County BALTIMORE
City or town RELAY
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1712 GLOVER ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ROSE MARIE DODSON

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single (INFANT)

6.(b) Name of husband or wife NONE
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 4, 1945

8. AGE: Years	Months	Days	If less than one day
1	4	23	hrs. min.

9. Birthplace (Town, county, and state)
10. Usual occupation None
11. Industry or business None

FATHER 12. Name WILLIAM AMOS DODSON
13. Birthplace VA.

MOTHER 14. Maiden name ELIZABETH KANE
15. Birthplace BALTO. Md.

16. Informant MRS. ELIZABETH DODSON
Address 1712 GLOVER ST. RELAY Md.

17. Burial Date thereof 1/30/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Salem Lutheran
Location Catonsville Md.

18. Funeral director Williams Cook, Inc.
Address 1217 St. Paul St.

19. 1/30 1947 A. W. Hedrick Dr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 27 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1946, to Jan 27 1947
and that I last saw h alive on Jan 11 - 47 19

Immediate cause of death	DURATION
Whooping Cough	
Bronchial-Pneumonia	2 days.
Due to. Whooping Cough.	4 wks.
Due to.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Paran M. D.
M. D. or other
Address 1711 Edmondson Ave. Date signed 1/29/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 ★ 00216

CERTIFICATE OF DEATH

Reg. Dist. No. 41

P.

1. PLACE OF DEATH:
County: Baltimore - 22.
City or town: Dundalk (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years.
Hospital, Institution, or street address where death occurred: 2605 Gray Manor Ter.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: County:
City or town: as in #1. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rachel Rebecca Dugger.

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow.

B.(b) Name of husband or wife: Jasper Newton Dugger.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 1. 1884.

8. AGE: Years: 62 | Months: 11 | Days: 22 | If less than one day: hrs. min.

9. Birthplace: Tazewell. Va. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: own home.

FATHER
12. Name: J. R. Sparks.
13. Birthplace: Tazewell. Va.

MOTHER
14. Maiden name: Patsy Harmon.
15. Birthplace: Va.

16. Informant: Mrs. Patsy Walker.
Address: as in #1.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1/23/47 (month) (day) (year)
Cemetery or crematory: Maple Hill Cem.
Location: Bluefield. Va.

18. Funeral director: Wm Cook Jno.
Address: 317 S. Paul St.

19. 1/23 19 47 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 23. 1947, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1947, to Jan 23. 1947
and that I last saw her alive on Jan 21 1947

Immediate cause of death	DURATION
Myocardial failure	Sudden
Due to: Arteriosclerosis.	3 yrs.
Due to: Hypertensive cardio	3 yrs.
Other conditions: Vascular disease.	4

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis N. Colli, M.D. M. D. or other
Address: 6908 North Point Rd. Balto 19 Md. Date signed 1/23/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

44 b

00217 44

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Baltimore

City or town: Chesapeake Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 601 Rosedale Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balt.

City or town: Chesapeake Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 601 Rosedale Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Hirchel P Duvall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Margaret

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10 1901

8. AGE: Years: 45 | Months: 6 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Mannington W Va

(Town, county, and state)

10. Usual occupation: Roofer

11. Industry or business

FATHER — 12. Name: Joseph H Duvall

13. Birthplace: Va

MOTHER — 14. Maiden name: Martha E Madden

15. Birthplace: Penna

16. Informant: Richard H Duvall

Address: 726 S London Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-23-47 (month) (day) (year)

Cemetery or crematory: Emmasburg

Location: Emmasburg Md

18. Funeral director: Percy A Finley

Address: Catonsville Md

19. Jan 23 - 1947 (Date rec'd by registrar) D. S. Parker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/20 1947 at 7 7 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/6 1946, to 1/20 1947

and that I last saw h... alive on 1/13 1947

Immediate cause of death: Hodgkin's disease — Duration: 1 yr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A L Kolodny M.D.

M. D. or other

Address: 458 Edgewater Apt. Balto. 11, Md. Date signed: 1/20/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

127a

00218

CERTIFICATE OF DEATH

Reg. Diat. No. 57

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparks

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sparks (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Quaker Bottom Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Lucinda Dyett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widow

6.(b) Name of husband or wife: Jame Dyett

6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): Nov. 30, 1861

8. AGE:

Years	Months	Days	If less than one day
85	1	22	hrs. min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER

12. Name: John Jackson

13. Birthplace: Balto. Co. Md.

MOTHER

14. Maiden name: Lucy Barber

15. Birthplace: Balto. Co. Md.

16. Informant: James M. Dyett

Address: Offutt Bldg. Towson 4 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 25, 1947 (month) (day) (year)

Cemetery or crematory: Graglia

Location: Cuba Rd., Lochearn Md

18. Funeral director: Saunders M. Brooks

Address: Sparks, Md.

19. 1 - 25 47 (Date rec'd by registrar) Wilmer O. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 January 1947, at 12:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Jan. 1947 to 22 Jan 1947 and that I last saw her alive on 21 Jan 1947

	DURATION
Immediate cause of death: Acute Congestive Failure	
Due to: Arteriosclerosis	
Due to:	
Other conditions: Cholecystitis - Arthritis Cystitis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Walter T. Kees M. D.
M. D. or other

Address: Cockeysville, Md. Date signed: 24 Jan. 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107 ✱ 00219 P

CERTIFICATE OF DEATH

Reg. Dist. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Balto
City or town Randallstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Offutt Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Balto
City or town Randallstown (If outside city or town limits, write RURAL and give nearest town)
Street No. Offutt Rd (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Linda Carole Edmundson

3.(b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) June 17 1945

8. AGE: Years 1 Months 7 Days 4 If less than one day ... hrs. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Child
11. Industry or business

FATHER
12. Name Robert M. Edmondson
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden name Grace E. Dana
15. Birthplace Baltimore Co. Md

16. Informant Mrs. Robert M. Edmondson
Address Offutt Rd. Randallstown Md

17. Burial Date thereof Jan 23 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt Olive
Location Randallstown, Md

18. Funeral director E. Willis Lamoreau
Address 4510 Liberty Heights Ave.

19. 1/22 19 47 A. W. Hebrank
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 21 19 47 at 9a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death: Suffocation due to
Due to regurgitation of mucus
Due to Bronchopneumonia

DURATION

Other conditions sudden death
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo McKieffer Dep Med Ex Balto Co
M. D. or other
Address 1010 Leeds Ave Date signed 1-21-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

00220

CERTIFICATE OF DEATH

★ Reg. Dist. No. 330

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo
Hospital, Institution, or street address where death occurred: Dolfield Road Owings Mills
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Owings Mills Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Dolfield Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Caroline Jean Edwards

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 11th. 1946

8. AGE: Years | Months 4 | Days 28 | If less than one day: hrs. min.

9. Birthplace: Owings Mills Balto. Co., Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Virgus S. Edwards
13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Caroline Hensley
15. Birthplace: North Carolina

16. Informant: Virgus S. Edwards
Address: Owings Mills Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 1/10/47
(month) (day) (year)
Cemetery or crematory: Edwards Cemetery
Location: Cairo River, N.C.

18. Funeral director: Wm. Berryman Sons
Address: Reisterstown Md

19. Jan 9 1947 Mary B. Elmo
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 8th 1947, at 9 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6, 1947, to Jan 8 1947
and that I last saw h alive on Jan 8, 1947

Immediate cause of death	DURATION
Bronchial Pneumonia	2
Due to: Cold	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jas. E. Master M. D. or other
Address: Randallstown Md Date signed 1/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00221

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 6339 Frederick Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6339 Frederick Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Helen G. Edwards

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: John

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 30 1866

8. AGE: Years: 90 | Months: 7 | Days: 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Mason City W. Va. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Thos. G. Farley

13. Birthplace: Richmond Va.

MOTHER — 14. Maiden name: Eliz abeth Scott

15. Birthplace: England

18. Informant: John Edwards Jr

Address: 6339 Frederick Ave

17. (Burial, cremation, or removal (which?)) Burial Date thereof 1-7-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Washington D C

18. Funeral director: George M Farley

Address: Catonsville Md

19. 1-5-1947 (Date rec'd by registrar) Harry J. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 19 47 at 2:1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov-28 1947 to Jan-4 1947 and that I last saw h.. alive on Jan-4 1947

Immediate cause of death	DURATION
Acute Nephritis	4 years
Due to Col Followed by Pneumonia	1 wk
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE S. Lloyd Johnson M. D. or other

Address: Catonsville Md Date signed 1-4-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00222

CERTIFICATE OF DEATH

Reg. Dist. No. 7-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore Dundalk
City or town Box 50 Stansbury Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Box 50 - Stansbury Road
(If outside city or town limits, write RURAL and give nearest town)
Street No. Dundalk 22 Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jennie Edwards

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife James F. Edwards
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 28th 1875

8. AGE:

Years	Months	Days	If less than one day
71	11	26	..... hrs. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name Joshua Robinson
13. Birthplace Unknown
MOTHER 14. Maiden name Martha "
15. Birthplace " "
16. Informant Elsie Garcia
Address Box 50 Stansbury Rd - Dundalk 22
17. Burial Date thereof 1/27/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Western
Location Balto. Md.
18. Funeral director William Cook Inc
Address 1217 St. Paul St
19. 1/25 47 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24th 1947, at 7:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to January 24th 1947
and that I last saw h alive on June 23 1946
Immediate cause of death Lobar Pneumonia — DURATION 5 days
Due to Arteriosclerosis — DURATION Indefinite
Due to Chronic Parenchymatous nephritis — DURATION Indefinite
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. C. Thomas M.D.
M. D. or other
Address Dundalk Md. Date signed 1/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00223 8

CERTIFICATE OF DEATH

Reg. Dist. No. 4K

1. PLACE OF DEATH:

County: Baltimore

City or town: Edgemere

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, Institution, or street address where death occurred: None

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Edgemere

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box #310 Ruth Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John E. Krbacker

3.(b) Social Security Number: 217-05-0976

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: May

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 13 - 1882

8. AGE: Years: 65 74 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Philip E. Krbacker

13. Birthplace: Balto.

MOTHER — 14. Maiden name: Ora Vondron

15. Birthplace: Germany

16. Informant: Rose Ripken (sister)

Address: Box 10 - Edgemere 19 - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/10/47 (month) (day) (year)

Cemetery or crematory: Sacred Heart

Location: German Hill Rd.

18. Funeral director: Lilly & Riley, Inc.

Address: 403 S. Wolfe St

19. 1/9/47 (Date rec'd by registrar) A. L. Bedrest Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7th 1947, at 5:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15th 1946 to Jan 7th 1947

and that I last saw him alive on January 6th 1947

Immediate cause of death: Lobar Pneumonia — DURATION: 3 wks

Due to: .....

Due to: .....

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Thomas M.D.

M. D. or other

Address: Dundalk Md. Date signed 1/7/47

VS A15 9-45.15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00224

CERTIFICATE OF DEATH

Reg. Dist. No. 430

1. PLACE OF DEATH:

County Baltimore

City or town Razerburg (Baltimore-6 Md)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Baltimore

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No. Ridge Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME FREDERCK ENDER.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	widowed.

6.(b) Name of husband or wife Carrie S Ender

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 16 1869

8. AGE: Years 78 | Months - | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Truck farmer

11. Industry or business

FATHER 12. Name Henry Ender
13. Birthplace -

MOTHER 14. Maiden name -
15. Birthplace -

16. Informant Mrs Harris
Address Ridge Road

17. Burial Date thereof 1/29/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peters Lutheran
Location Fullerton

18. Funeral director Lazarus Funeral Home
Address 7401 Belair Rd Balto 6 Md

19. Jan. 28 1947 Mrs. A. L. Richardson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1947, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1946, to Jan 27 1947 and that I last saw him alive on Dec 26 1946.

Immediate cause of death	DURATION
Coronary thrombosis	?
Due to Coronary arteriosclerosis	
Due to	
Other conditions General Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE H R Fuller
M. D. or other

Address Ridge Road Date signed 1/27/47
Baltimore-6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00225

89a

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural near Parkton.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Rural near Parkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mt. Carmel Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Eugene Francis Ensor.

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 14, 1946

8. AGE:

Years	Months	Days	If less than one day
0	4	7	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Clyde M. Ensor
13. Birthplace: Sparks, Md.

MOTHER
14. Maiden name: Melva F. Miller.
15. Birthplace: Parkton, Md.

16. Informant: Clyde M. Ensor
Address: Parkton, Md. R.D. #1.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 24. 1947 (month) (day) (year)
Cemetery or crematory: Wiseburg Cemetery.
Location: Parkton, Md.

18. Funeral director: Jacob Hartsteins
Address: New Freedom Pa.

19. Jan 23 1947 (Date rec'd by registrar) Liberty L Fuller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21, 1947, at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 1946, to Jan. 21, 1947
and that I last saw h... alive on Jan. 21, 1947

Immediate cause of death: Encephalitis — DURATION: 1 day

Due to:

Due to:

Other conditions: Otitis media

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. M. France M. D. or other
Address: Parkton Md. Date signed: 1/24/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2-350 — 2-10

00226 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Baltimore — 19 —

City or town: Sparrows Pt. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred: 7317 Walnut Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Dundalk #1. (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: MAURICE E. EULRICH.

3. (b) Social Security Number: 214-01-4195

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Louisa F Eulrich

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Jan 2. 1877.

8. AGE: Years	Months	Days	If less than one day
70	0	28	...hrs. ...min.

9. Birthplace: Milton, Pa. (Town, county, and state)

10. Usual occupation: Boiler Maker.

11. Industry or business: Oil Company.

FATHER — 12. Name: Lyman Eulrich.

FATHER — 13. Birthplace: Reading, Pa.

MOTHER — 14. Maiden name: Ellie Leib.

MOTHER — 15. Birthplace: New Columbia, Pa.

16. Informant: wife. Address: address as above.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/3/47 (month) (day) (year)

Cemetery or crematory: Bethlehem

Location: Baltimore Co. Md.

18. Funeral director: Wilson & Son

Address: 1214 E. Lond St.

19. 1/31/47 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 30. 1947 at 10 30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19... to Jan 30 1947

and that I last saw h. alive on Jan 30 1947

	DURATION
Immediate cause of death: Metastasis.	2 month.
Due to: of prostatic.	4 or 5 months
Due to: Carcinoma.	
Other conditions: decubitus ulcers	2 months.

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Louis N. Tallin M.D. M. D. or other

Address: 6908 N. Pt. Rd Balto 19 Date signed: 1-30-47

1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0228

932

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

54 Shipsway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 54 Shipsway

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Wallace Fisher

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widow

6.(b) Name of husband or wife Addie (Talley)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 2 - 1874

8. AGE:	Years	Months	Days	If less than one day
	72	2	5	..... hrs. ..... min.

9. Birthplace Deals Island, Md.

(Town, county and state)

10. Usual occupation Watchman

11. Industry or business

MOTHER FATHER

12. Name Henry Fisher

13. Birthplace Md

14. Maiden name Mary Webster

15. Birthplace Md

16. Informant Mrs. Thomas Burke

Address 54 Shipsway, Dundalk, Md.

17. Burial Date thereof Jan. 9. 47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Eastern Blvd.

18. Funeral director John G. Connelly

Address 418 Eastern Blvd.

19. 1-9- 1947 John G. Connelly

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7-47 19 47 at 1.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-5-47 19 47 to 1-7 19 47 and that I last saw h. alive on 1-7 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 Days
Due to Arteriosclerosis	7 years
Cardio vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eugene F. Neve M. D. or other

Address 7001 Monroe St. Dundalk, Md. Date signed 1-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-440 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 00229

Reg. Dist. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore County
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred: 2108 Gwynn Oak Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore Co.
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2108 Gwynn Oak Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Jane Fitschen

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: William F. Fitschen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 23, 1869

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	11	3		

9. Birthplace: Baltimore (Town, county, and state) Md.
10. Usual occupation: Home - retired
11. Industry or business: own home

FATHER	12. Name	Frederick F. Bushman
	13. Birthplace	?
MOTHER	14. Maiden name	Sarah Sheldon
	15. Birthplace	?

16. Informant: Mrs Adolph Peterson
Address: 2108 Gwynn Oak Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/29/47 (month) (day) (year)
Cemetery or crematory: Greenmount Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 1/27 19 47 A.W. Hedrick DR Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26 19 47, at 5.20 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 40, to Jan. 26 19 47 and that I last saw h[illegible] alive on January 26 19 47

Immediate cause of death	DURATION
Chronic Myocardial Degeneration	3 yrs
Due to	
Due to	
Other conditions: Pernicious Anaemia (Include pregnancy within 3 months of death)	7 yrs

Major findings of operations: no operation Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joshua H. Womacost M.D.
M. D. or other
Address: 649 Windsor Mill Rd Date signed: Jan 26
Baltimore-7 Md 1947

Evidence for the change of year of birth is shown on Y. 108 - 7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1025 (180) 00230

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 hours
Hospital, institution, or street address where death occurred:
Baltimore County Police Station
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: York Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Milford Flowers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethel May Burton
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): March 11, ~~1880~~ 1878

8. AGE: Years	Months	Days	If less than one day
68	9	21	....hrs. ....min.

9. Birthplace: Lutherville, Maryland (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Maryland Jockey Club
FATHER 12. Name: Milford Flowers
FATHER 13. Birthplace: Harford Co., Md.
MOTHER 14. Maiden name: Kate Price
MOTHER 15. Birthplace: Balto. Co., Md.
16. Informant: Mrs. Ostenkamp
Address: Harve de Grace, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 3, 1947 (month) (day) (year)
Cemetery or crematory: Moreland Memorial Park
Location: Parkville, Maryland
18. Funeral director: John Burns Sons
Address: Towson, Maryland
19. Jan 2 1947 (Date rec'd by registrar) H. Harold Hagen Deputy Clerk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1 1947 at 5:10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h... alive on ....19....
Immediate cause of death: Suffocation, accidental fire — DURATION 1/1/47
Due to:
Due to:
Other conditions: Abrasions, acute — 1/1/47
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accidental Date of 1/1/47
Where did injury occur? Towson (City or town) Baltimore (County) Md. (State)
Injured at home, farm, industry, public place (where?): Police Station (call Block)
Means of injury: Suffocation, accidental fire Injured at work? No
23. SIGNATURE: Rollin E. Hudson M.D. D.M.E. M. D. or other
Address: Towson Md Date signed 1/1/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-380-1-10

00227

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 47c

Baltimore

1. PLACE OF DEATH:

County: Fort Howard

City or town: Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 84 days

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
Fort Howard, Maryland

How long in hospital or institution? 84 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3203 N. Charles St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: THOMAS JAY FLUHARTY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Mai Seaman Fluharty

7. Birth date of deceased (mo., day, yr.): June 3, 1894 — 6.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
52	5	19	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed — Steamen

11. Industry or business

FATHER
12. Name: Thomas Fluharty
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Florence Matthews
15. Birthplace: Iowa

16. Informant: Registrars Office, Clin. Records
Address: VAH Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/24/47 (month) (day) (year)

Cemetery or crematory: David Rider

Location: Pikesville Md.

18. Funeral director: William Cook Inc

Address: 1219 St. Paul St.

19. 1/24 19 47 A. W. Hedrick Dir. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 19 47 at 9:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30 19 46 to January 22 19 47 and that I last saw him alive on January 22 19 47

Immediate cause of death	DURATION
CARCINOMA OF THE RIGHT BRONCHUS WITH METASTASIS TO LIVER AND PANCREAS	4 mos.
Due to:	
Due to:	
Other conditions: Incisional Hernia, Right Upper Abdomen (Include pregnancy within 3 months of death)	8 yrs.

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D., CLIN. DIR. M. D. or other

Address: V.A., FT. HOWARD, MD. Date signed 1-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-7

01029

CERTIFICATE OF DEATH

Reg. Dist. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years, 10 months, 11 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 21 years, 10 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2323 North Calvert Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Georgianna Ford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2, 1859

8. AGE: Years: 87 Months: 7 Days: 27 If less than one day: hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER 12. Name: Joseph Young Ford

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Elizabeth Deems

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-25-47 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Md.

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Md.

19. Feb 25 1947 (Date rec'd by registrar) Harry [illegible] Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29, 1947, at 6:35p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18, 1925, to January 29, 1947 and that I last saw her alive on January 29, 1947

Immediate cause of death	DURATION
Chronic pyelonephrosis	indefinite
Acute appendicitis	"
Due to: Carcinoma of the liver	"
Generalized arteriosclerotic	
Due to: cardiovascular-renal disease	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 2-24-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00231 8

97

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Recent

Hospital, Institution, or street address where death occurred: 5501 Edmondson Ave

How long in hospital or Institution? Recent

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town Lyndale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Patapsco Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harry W Garrott

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary E

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 4 1873

8. AGE: Years 73 | Months 7 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Ga (Town, county, and state)

10. Usual occupation House painter

11. Industry or business

FATHER 12. Name Charles Garrott

FATHER 13. Birthplace Ga

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace

16. Informant Harry W John

Address 12 Patapsco Ave

17. Buried (Burial, cremation, or removal. Which?) Date thereof 1/18/47 (month) (day) (year)

Cemetery or crematory Mt Olivet Cathedral

Location Baltimore Md

18. Funeral director Mellvorn Funeral Home

Address 1219 E Fort Ave

19. 1-16 1947 Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1947 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1946 to June 14 1946

and that I last saw h[illegible] alive on June 13 1947

Immediate cause of death Cerebral arteriosclerosis

uremia

DURATION several months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Milton B Kress M. D. or other

Address Med arts Bldg Date signed 1/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

942 DC ★ 00232 381

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Baltimore Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Mercy Villa, Bellona Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5908 Benton Heights Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martha M. Gatch

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Harry Lee Gatch, sr.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 31st, 1874

8. AGE: Years	Months	Days	If less than one day
72	4	28	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER 12. Name: Samuel Barry

13. Birthplace: Md.

MOTHER 14. Maiden name: Rachael ?

15. Birthplace: ?

16. Informant: Mrs. Chase Thomas

Address: 5906 Benton Heights Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/30/47 (month) (day) (year)

Cemetery or crematory: Parkwood Cem.

Location: Baltimore, Md.

18. Funeral director: Leonard J. Ruck

Address: 5305 Harford Road

19. 1/30 19 47 A. M. Hedrick per LR Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28th, 19 47 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 19 47 to Jan 28 19 47 and that I last saw her alive on June 9, 1947 19

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to: Arteriosclerosis.	
Due to:	
Other conditions: Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Geraghty Jr M. D. or other

Address: 3047 Poplar St Date signed: 1/29/47

Dr. Morris Jacobs
617 Northpoint Road

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

617 ★ 00233 Reg. Dist. No. 4

8

1. PLACE OF DEATH:
County: Dundalk
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
30 Lombardy Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dundalk
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 30 Lombardy Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lena R. Goetz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Albert R. Goetz
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1877

8. AGE: Years	Months	Days	If less than one day
69	--	18	hrs. min.

9. Birthplace: Huntingdon, Pa.
(Town, county, and state)
10. Usual occupation: at home
11. Industry or business

FATHER
12. Name: ? Crawford
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Mr. Charles H. Goetz, son
Address: 30 Lombardy Drive, Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/13/47 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Pa.

18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Road, 14.

19. 1-10 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10th, 1947, at 6 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 1947 to January 9 1947 and that I last saw her alive on Jan 9 1947

Immediate cause of death	DURATION
Coronary Embolism	1 day
Due to: Arteriosclerosis, Thyroid Disease (Toxic Goiter)	
Due to:	
Other conditions: Chronic Gall-Bladder	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. A. Jacobs MD M. D. or other
Address: 617 North Pt Rd Date signed: 1/10/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00234

Reg. Dist. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Delta
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Delta
(If outside city or town limits, write RURAL and give nearest town)
Street No. 55 Delta Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Estella Gertrude Groff

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Harry Groff
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1886

8. AGE: Years	Months	Days	If less than one day
60	9	4	hrs. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual occupation At home
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant Harry Groff
Address Delta Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-31-47 (month) (day) (year)
Cemetery or crematory Good Shepherd
Location Elliott City Md.

18. Funeral director J. C. Digumbothom
Address Elliott City Md

19. 1-30 1947 (Date rec'd by registrar) Harry D. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1947 at 11 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1 1946 to 1-27 1947
and that I last saw her alive on 1-27-47 1947

Immediate cause of death	DURATION
Hypertensive Cardio Vascular disease	1 year instant
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George E. Burgtorf M.D. M. D. or other
Address Elliott Citys, Md. Date signed 1-29-47

#10 Magruder

1-BS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d ★ rc 00235

CERTIFICATE OF DEATH

Reg. Diat. No. 371

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Cockeysville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred: Masonic Home Cockeysville

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County

City or town Baltimore Md (If outside city or town limits, write RURAL and give nearest town)

Street No. 3116 Presbury St (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME William Alfred Grokpel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Celia Muse Grokpel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1871

8. AGE: Years	Months	Days	If less than one day
75	4	16	..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Paint & Varnish Mfg.

11. Industry or business

FATHER 12. Name Peter H. Grokpel

13. Birthplace Prussia

MOTHER 14. Maiden name Katherine L. Schanfelberger

15. Birthplace Baltimore Md

16. Informant Laura M. Schroeder

Address Masonic Home Cockeysville

17. Burial (Burial, cremation, or removal. Which?), Date thereof Jan 25 47 (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Baltimore Md

18. Funeral director Wm. Cook

Address St. Paul & Preston Sts

19. 1/23 1947 Laura M. Schroeder

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1947, at 5-25 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 7 1946, to Jan 22 1947 and that I last saw h.. alive on Jan 22 1947

Immediate cause of death	DURATION
Congestive heart failure	
Due to arteriosclerosis	
Due to	
Other conditions Parkins Syndrome	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Walter T. Kuss M. D. or other

Address Cockeysville Md Date signed 1/22/47

1-25

2-370-1-10

00236 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Balto.

City or town 21 E. Overlea Ave

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 E Overlea Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna C. Haebler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife Louis T.

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Oct 21 1883

8. AGE:	Years	Months	Days	If less than one day
	63			...hrs. ...min.

9. Birthplace Balto (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name John Lang

13. Birthplace Germany

MOTHER 14. Maiden name Gertrude Vogel

15. Birthplace Germany

16. Informant Louis T. Haebler

Address 21 E. Overlea Ave

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JAN 10 1947 (month) (day) (year)

Cemetery or crematory HOLY REDEEMER

Location 4300 BELAIR ROAD.

19. Funeral director MARTIN W.E. DIPPEL'S SONS

Address 7110 BELAIR ROAD

19. 1-8 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1947 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1940 to Jan 7 1947 and that I last saw h... alive on Jan 7 1947

	DURATION
Immediate cause of death	
Myocardial insufficiency	3 days
Due to	
Chronic hypertension	7 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edw. A. Benson M. D. or other

Address 1 W. Overlea Ave Date signed 1/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

560 00237 P

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 164 days

Hospital, Institution, or street address where death occurred: Vet. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution? 164 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Brooklyn 25, Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. 405 E. Doris Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: SAVIA HANZOOK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mrs. Anna T. Hanzook

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): December 1, 1895

8. AGE:

Years	Months	Days	If less than one day
51	1	25	....hrs. ....min.

9. Birthplace: Russia (or) Poland (Town, county, and state)

10. Usual occupation: ~~Unemployed~~ Machinist

11. Industry or business:

FATHER 12. Name: ~~Unknown~~ Zachery Hanzook

13. Birthplace: ~~Unknown~~ Poland

MOTHER 14. Maiden name: ~~Unknown~~ Pearl ?

15. Birthplace: ~~Unknown~~ Poland.

16. Informant: Clinical Records, VEt. Adm. Hosp

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/29/47 ~~-25-46~~ (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Martin Dippel

Address: 37 S. Ann St., Baltimore, Md.

19. Jan 27 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26 1947 at 8:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14th 1946 to January 26 1947 and that I last saw him alive on January 26 1947

Immediate cause of death: Brain tumor, type undetermined, right frontal and temporal lobes — DURATION: 9 mon.

Due to:

Due to:

Other conditions: Hemiplegia, left

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Roderic M. Cullison R.M. CULLISON, M.D. Clinical Director

Address: VAH. Fort Howard, Md. M. D. or other

Date signed: Jan.26,47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 002838

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: BALTIMORE

City or town: TOWSON

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years, 3 months, 2 days

Hospital, institution, or street address where death occurred:

SHEPPARD AND ENOCH PRATT HOSPITAL

How long in hospital or institution? 6 years, 3 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1738 Upshur Street, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3. (a) FULL NAME

HARVESTSTRAW, EDNA LOUISE ZINN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: J. Carol Harveststraw

6.(c) If alive, give age: 56? years

7. Birth date of deceased (mo., day, yr.): July 12th, 1896

8. AGE: Years	Months	Days	If less than one day
50	5	28	..... hrs. ..... min.

9. Birthplace: Philadelphia, Penna. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: .....

FATHER

12. Name: William Theodor Zinn

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Louise Meister

15. Birthplace: Pennsylvania

16. Informant: HOSPITAL RECORDS

Address: .....

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 1/11/47 (month) (day) (year)

Cemetery or crematory: .....

Location: Washington, D.C.

18. Funeral director: W.R.F. Hines

Address: 2901 14th Street Washington D.C.

19. 1-11 (Date rec'd by registrar) 19 47 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10th 19 47, at 11:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 8th 19 40, to January 10th 19 47

and that I last saw her alive on January 10th 19 47

Immediate cause of death	DURATION
Mediastinal abscess with perforation into both pleural cavities	24 hrs.
Due to:	.....
Due to:	.....
Other conditions: Involutional Melancholia	9 yr

(Include pregnancy within 3 months of death)

Major findings of operation: .....

Date of op. .....

Autopsy results: As above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. W. Elgin

W. W. Elgin, M. D. M. D. or other

Address: TOWSON, MD. Date signed: Jan. 10, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18/12

1028

00239

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore

City or town Towson
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: 100 Greenridge Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 9 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Towson Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 100 Greenridge Rd.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME William Ferdinand Haupt

3. (b) Social Security Number —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Elizabeth Favorite

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 28, 1862

8. AGE: Years 84 | Months 11 | Days 8 | If less than one day — hrs. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business House Painter

FATHER 12. Name Mathias Haupt

FATHER 13. Birthplace Balto. Md.

MOTHER 14. Maiden name Elizabeth Favorite

MOTHER 15. Birthplace Maryland

16. Informant Edward F. Haupt

Address 100 Greenridge Rd., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 8, 1947 (month) (day) (year)

Cemetery or crematory Mt. Olivia Cemetery

Location Towson, Md.

18. Funeral director John Burns' Sons

Address Towson, Md.

19. Jan 7, 1947 (Date rec'd by registrar) [illegible] County, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5, 1947, at 8± A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—, to ——— 19—, and that I last saw h— alive on ——— 19—.

Immediate cause of death Cardio-renal-vascular disease, chronic

Due to Arteriosclerosis

Due to Senile changes

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION
Unknown
1 yr
1 yr +

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bollin C. Hudson M.D. D.M.E.
M. D. or other

Address Towson Md Date signed 1/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-380- 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

00240

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Baltimore

City or town Notch Cliff, near Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Notch Cliff, near Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sister Mary Viatora Haverkamp

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1869

8. AGE: Years	Months	Days	If less than one day
77	8	16	hrs. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Teacher

11. Industry or business

FATHER 12. Name Charles Haverkamp

13. Birthplace Baltimore

MOTHER 14. Maiden name Anna Mary Bockrage

15. Birthplace Baltimore

16. Informant Sr. Mary Clara

Address Notch Cliff, Md.

17. Burial Date thereof Feb 1 '47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Notch Cliff

Location Glen Arm Md

18. Funeral director Geo M Smith & Son

Address 611 N Wolfe St

19. (Date rec'd by registrar) 19 H. M. Hennegan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 19 47, at 8.40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 29 19 45, to Jan 29 19 47

and that I last saw him alive on Jan 29 19 47

Immediate cause of death Carcinoma of breast — DURATION 2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore - 19.
City or town: Sparrows Point.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1928
Hospital, institution, or street address where death occurred: 6809 North Point Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: As un # 1.
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME WILLIAM JOSEPH HEILMAN.

3.(b) Social Security Number 212-09-5542

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Ella Rebecca Heilman. 6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Sept. 5 - 1874

8. AGE: Years: 72 | Months: 4 | Days: 26 | If less than one day: hrs. min.

9. Birthplace: Kelly Station. Pa. (Town, county, and state)

10. Usual occupation: Operator.

11. Industry or business: Filling Station.

FATHER — 12. Name: Zachariah Tomer Heilman

13. Birthplace: Pa.

MOTHER — 14. Maiden name: Rosanna Klingelsmith

15. Birthplace: Pa.

16. Informant: Ella Heilman

Address: As un # 1.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/3/47 (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: Dundalk Ave Ext.

18. Funeral director: Tully & Zeuler Inc

Address: 403 E. Fayette St.

19. 1/31 19 47 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31. 1947, at 10 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 37 to Jan 31 19 47.

and that I last saw him alive on Jan 31 19 47.

Immediate cause of death	DURATION
myocardial decompensation	2 days.
Due to: Hypertension. Cardio Vascular Renal	6 yrs.
Due to:	
Other conditions: Hemiplegia.	26 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Louis N. Hollin M.D. (M. D. or other)

Address: Sparrows Point. Md. Date signed: 1/31/47

additions made as per phone conversation with John Connelly, Funeral Director, 2/5/47 PRC.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108 00242

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Brooklawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Brooklawn
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Howell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
65 ?			hrs. min.

9. Birthplace (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace
MOTHER 14. Maiden name
15. Birthplace
16. Informant
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof jan. 15, 1947 (month) (day) (year)
Cemetery or crematory
Location Texas Alms House
18. Funeral director John D. Connelly
Address 418 Eastern Ave. C
19. Jan 15 1947 John D. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1947, at 10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14 1947 to 19
and that I last saw h alive on January 14 1947
Immediate cause of death Lobar pneumonia — DURATION 2 day.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford F. Johnson M.D. M. D. or other
Address Fork Md. Date signed 1/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

931

Reg. Dist. No. 0024370

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Harvey Edw. Henry

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male.	White	Widowed

6.(b) Name of husband or wife: Maggie (nee Hunt)

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 5, 1878

8. AGE: Years	Months	Days	If less than one day
68	6	0	..... hrs. ..... min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Peter Henry
13. Birthplace: Balto Co. Md.

MOTHER
14. Maiden name: Mary Hall
15. Birthplace: Balto. Co. Md

16. Informant: Mrs. Gladys Willelmi
Address: Cockeysville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 7, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Zion

Location: Upperco Balto. Co. Md

18. Funeral director: Sandon M. Bowles
Address: Sparks, Md.

1-5- 47 Wilmer C. Ensor
19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 5 1947, at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-21 1943, to 1-5 1947 and that I last saw him alive on 1-3 1947

Immediate cause of death	DURATION
Hypertensive C-V. Disease	5 yrs
Arteriosclerosis	5 yrs
Due to: Broncho Pneumonia	3 da.
Due to:	
Other conditions: Prostatic Enlargment	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None.

Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury None. Injured at work?

23. SIGNATURE: D. D. Eagles, M.D.
M. D. or other

Address: Reisterstown, Md. Date signed 1-5-'47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 ★ 00244

Reg. Dist. No. 4-2

1. PLACE OF DEATH:
County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Arbutus
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1333 Poplar Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Maude D. Herrick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Joseph F.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 27, 1886

8. AGE: Years	Months	Days	If less than one day
60	11	29	hrs. min.

9. Birthplace: Ohio
(Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: George Fullmer
13. Birthplace: Ohio

MOTHER
14. Maiden name: — Custer
15. Birthplace: Ohio

16. Informant: Mr. Joseph Herrick
Address: 1336 Poplar Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-29-47 (month) (day) (year)
Cemetery or crematory: London Park
Location: 3801 Frederick Rd.
18. Funeral director: Harry F. Witzke
Address: 4101 E. Monument Ave.

19. 1/29 19 47 (Date rec'd by registrar) F.W. Hebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26 19 47 at 7 30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 19 46 to Jan 26 19 47 and that I last saw her alive on Jan 26 19 47

Immediate cause of death	DURATION
Adenocarcinoma of Sigmoid	1 yr?
Generalized Metastases	6 mos?
Due to:	
Due to:	
Other conditions: Jaundice - Acidosis	2 mos 2 wks.

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Sigmoid, Partial Intestinal Obstruction Date of op. Sept 1946

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Earl Pass M.D.
M. D. or other
Address: 4001 Wilkens Ave Date signed: 1-26-47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

00245 B

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: at home
How long in hospital or institution? (" " ")

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State Md County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 126 Oakdale
(If rural, give LOCATION)
2.(a) If veteran, name war (none)

3.(a) FULL NAME William George Stisky

3.(b) Social Security Number 216-09-4572

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Isabelle N. Stisky
6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) June-4-1903

8. AGE: Years 43 Months 7 Days 10 If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore-Md. (Town, county, and state)
10. Usual occupation Insurance
11. Industry or business Insurance

FATHER 12. Name	Thos. Foley Stisky
FATHER 13. Birthplace	Balto. Md.
MOTHER 14. Maiden name	Hannah T. McClelland
MOTHER 15. Birthplace	Balto. Md.

16. Informant Mr. Lucian Stisky - (Bro.)
Address Maple Rd Catonsville
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan-17-47 (month) (day) (year)
Cemetery or crematory New Cathedral
Location Baltimore Md.
18. Funeral director Stewart Mortuary Company
Address 108 W. North Ave.
19. Jan 16 1947 (Date rec'd by registrar) A. W. Hodnett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14 1947 at 3 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/5 1946 to 1/14 1947 and that I last saw h... alive on 1/14 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Coronary Artery Disease	2 yrs.
Due to Hypertension	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas Norton Jr. M. D. or other
Address 1933 W. Balto St. Date signed 1/15/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00246

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 6 mos., 0 days
Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 6 mos., 0 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1207 Morling Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Eugene Hitt

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1927

8. AGE: Years	Months	Days	If less than one day
19	8	13	hrs. min.

9. Birthplace Baltimore, Maryland (Town, county, and State)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Otis Hitt
13. Birthplace Virginia

MOTHER
14. Maiden name Marie Brown
15. Birthplace Baltimore, Maryland

16. Informant Eugene Hitt
Address 1207 Morling Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 18, 1947 (month) (day) (year)
Cemetery or crematory Meadowridge Memorial
Location Washington Blvd., Balto., Md.

18. Funeral director Chenoweth & Donovan
Address 3615 Chestnut Ave., Balto., Md.

19. Jan. 14, 1947 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 1947, at 7:50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14, 1946, to Jan. 14, 1947 and that I last saw him alive on January 14, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	About 8 mos.
Due to Tubercle Bacilli	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. I. Siegel M.D.
M. D. or other
Address Date signed 1/14/47

Rec'd - 1-16-47 - Ez Nichols

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-3320- 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37-a)

CERTIFICATE OF DEATH

01028

Reg. Diat. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Meyer Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph B. Hohman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie A. Hohman

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): January 11, 1882

8. AGE: Years	Months	Days	If less than one day
64	11	29	hrs. min.

9. Birthplace: Hebbville, Md.
(Town, county, and state)

10. Usual occupation: Retired Laborer

11. Industry or business

FATHER — 12. Name: John Hohman
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Minnie Greenwalt
15. Birthplace: Maryland

16. Informant: Mrs. Joseph B. Hohman
Address: Randallstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 13, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Olive Cemetery

Location: Randallstown, Md.

18. Funeral director: Miles Edmondson

Address: 4510 Liberty Heights Ave.

19. 1/11/1947 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 19 47 at 8.55 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 24, 1946 to Jan. 10 1947 and that I last saw him alive on Jan 10 1947

Immediate cause of death: Chronic hypertrophy of prostate + Cystitis

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Harrisonville, Md. Date signed: 1/11/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 00247

Reg. Dist. No. 4-2

1. PLACE OF DEATH:

County BALTIMORE

City or town ARBUTUS
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
1306 Stevens Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County BALTIMORE

City or town ARBUTUS
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1306 STEVENS AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME JOHN O. HOLLAND

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife EVA E WALTEMEYER

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1885

8. AGE: Years	Months	Days	If less than one day
61	5	—	..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation THEATRE MANAGER

11. Industry or business

FATHER
12. Name JOSEPH F. HOLLAND
13. Birthplace UNKNOWN

MOTHER
14. Maiden name
15. Birthplace UNKNOWN

16. Informant EVA E. HOLLAND
Address 1306 STEVENS AVE

17. BURIAL Date thereof 1/21/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location BALTIMORE, Md.

18. Funeral director MARTIN FAHEY & SONS

Address 1827 W. NORTH AVE

19. Jan 18 1947 Dr. Kieffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1947 at 12-10 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to Cardiovascular disease	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. M. Kieffer Dep. Med. Exam'r
M. D. or other

Address 1010 Leadenhall Date signed 1-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00248

Reg. Dist. No. 337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Rural near Md. Line
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Rural near Parkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. East of Md. Line, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Benjamin Franklin Hollingshead

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Georgiana Amos.
6.(c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) May 14, 1878.

8. AGE: Years 68 | Months 8 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace Parkton, Md. R.D. (Town, county, and state)
10. Usual occupation Farming.
11. Industry or business Own farm.

FATHER
12. Name John Hollingshead
13. Birthplace Md.

MOTHER
14. Maiden name Rebecca J. Bahn.
15. Birthplace Md.

16. Informant Amos Hollingshead
Address Parkton, Md. R.D.

17. Burial (Burial, cremation, or removal: Which?) Date thereof Jan. 26, 1947 (month) (day) (year)
Cemetery ~~or crematory~~ West Liberty
Location White Hall, Md. R.D.

18. Funeral director Jacob Hartsuch
Address New Freedom, Pa.

19. Jan 25 1947 (Date rec'd by registrar) Charles L. Fenton Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24, 1947 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Dead on arrival at home	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. M. France M. D. or other
Address Parkton, Md. Date signed 1/25/47

1-25

2-350— 1-10

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00249 Reg. Dist. No. 41

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Days
Hospital, institution, or street address where death occurred: Vets. Adm. Hosp., Ft. Howard, Md.
How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Wic
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No.: Route # 1 (If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: ORAN W. HOPKINS
3. (b) Social Security Number: 215-14-3836

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: Single
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.): 7-31-1893

8. AGE:

Years	Months	Days	If less than one day
53	5	1	...... hrs. ...... min.

9. Birthplace: Wicomico Co., Md. (Town, county, and state)
10. Usual occupation: Weather Striper
11. Industry or business:

FATHER
12. Name: Alexander W. Hopkins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sallie Jones
15. Birthplace: Maryland

16. Informant: Registrar's Office, Clin. Records
Address: Vets. Adm. Hosp., Ft. Howard, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Jan 5 - 1947 (month) (day) (year)
Cemetery or crematory: Salisbury
Location: Salisbury - Md.
18. Funeral director: Ellsworth Armacost
Address: 3911 Liberty Heights Ave.
19. 1/7 1947 (Date rec'd by registrar) W M Carmine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2, 1947, at 5:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 21, 1946, to January 2, 1947, and that I last saw him alive on January 2, 1947.

Immediate cause of death	DURATION
Secondary necrotizing abscesses of tuberculous cavity of lungs	1 Month
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .... Date of op. ....
Autopsy results: Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work? ....

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR. M.D. or other
Address: V.A. Ft. Howard, Md. Date signed: 1-2-47

1-35

00251

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 380

1. PLACE OF DEATH:
County: Baltimore
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, institution, or street address where death occurred: Mountain Ave., Towson R.F.D. 6
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson R.F.D. 6
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mountain Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William W. Horan

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 11th, 1868

8. AGE: Years 79 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: [illegible] (Town, county, and state)
10. Usual occupation: Sheerman
11. Industry or business: U.S. Steel

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name: Catherine Wade
15. Birthplace: England

16. Informant: Mrs. Henry Doyle
Address: Mountain Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 27 1947 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: 4430 Belair Road
18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Road

19. 1/25 (Date rec'd by registrar) 19 47 A.M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 24, 1947, at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1946, to Jan. 2 1947 and that I last saw h[illegible] alive on Jan. 24, 1947

	DURATION
Immediate cause of death: Arteriosclerotic Heart Disease	
Due to: Chronic Nephritis	
Due to: Chronic Prostatic Hypertrophy	
Other conditions: Micturition	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. Nathan Janney M. D. or other
Address: 701 Harford Rd. Date signed 1/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

00250

CERTIFICATE OF DEATH

Reg. Dist. No. 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Fork (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred: New Cut Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Balto.

City or town Fork (If outside city or town limits, write RURAL and give nearest town)

Street No. New Cut Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME E. KATHERINE HORN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife John Horn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 15th, 1867

8. AGE: Years	Months	Days	If less than one day
79	1	7	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Pfeiffer

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace Germany

16. Informant Mr. George W. Horn

Address Belair Road, Glenarm, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Jan. 25, 1947 (month) (day) (year)

Cemetery or crematory St. Michaels Luth. Cemetery

Location Perry Hall, Md.

18. Funeral director Lansdale Funeral Home

Address 7401 Belair Road

19. 1/23/47 19 W. M. Hammett (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22nd, 1947 at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15 1946 to Jan. 22 1947 and that I last saw h.. alive on 22 Jan. 1947

Immediate cause of death	DURATION
Acute Cardiac dilatation	2 hrs.
Due to Chronic Myocarditis + arteriosclerosis.	3 yrs
Due to	
Other conditions Diabetis Mellitus (Mild)	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lloyd E. Saylor M. D. or other

Address 3902 Greenmount Ave. Date signed 22 Jan. 47

1-35

Evidence for the change of age is shown on G 108 1/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

00258

Reg. Diat. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 594 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Md.

How long in hospital or institution? 594 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Balto

City or town Stevenson
(If outside city or town limits, write RURAL and give nearest town)

Street No. None
(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3.(a) FULL NAME JOHN E. HURST of W

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Anne W. Hurst

6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 5-13-1893

8. AGE: Years	Months	Days	If less than one day
53	7	24	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name William B. Hurst

13. Birthplace Maryland

MOTHER 14. Maiden name Frances L. Bear

15. Birthplace Maryland

18. Informant Clinical Records, Vets. Adm. Hosp.
Address Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-10-47 (month) (day) (year)

Cemetery or crematory Green Mount

Location Baltimore

18. Funeral director Stuart Memorial Company

Address 1080 Mon Ave.

19. 1-10 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1947 at 8:20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 23, 1946, to January 7, 1947 and that I last saw him alive on January 7, 1947

	DURATION
Immediate cause of death: Coronary Occlusion	Sudden
Due to: Arteriosclerosis	
Due to:	
Other conditions: Healed Old Infarcts of left ventricle due to coronary Thrombosis, (Include pregnancy within 3 months of death)	2 Yrs.

Major findings of operations: ..... Date of op. .....

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison
R. M. CULLISON, M.D. CLINICAL DIRECTOR

Address V. A. H. Ft. Howard, Md. Date signed 1-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00253

Corrected ~~Copy~~

Reg. Dist. No. RC 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 212 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Md.

How long in hospital or institution? 212 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 222 E. Cross Street
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: Thomas E. Jennings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 11-9-97

8. AGE: Years	Months	Days	If less than one day
49	2	3	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: Peter Jennings
13. Birthplace: Ireland

MOTHER
14. Maiden name: Catherine Smith
15. Birthplace: Ireland

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/14/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: John J. Fahey & Sons
Address: 1318 Light St., Balto., Md.

19. 1/15/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 19 47 at 6:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 19 46 to January 12 19 47 and that I last saw h... im ...alive on January 12 19 47

Immediate cause of death	DURATION
Pulmonary tuberculosis, far advanced, bilateral	6-14-46 Plus
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Allison
R. M. ALLISON, M.D. CLIN. D. of Otos
Address: VAH Fort Howard, Md. Date signed .....

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48 b 011254 B

Reg. Dist. No. 3D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 5705 Edmondson Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5705 Edmondson Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Margaretta M. Johns

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William P. Johns
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 14th 1896

8. AGE: Years	Months	Days	If less than one day
50	3	12	..... hrs. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Rollins T. Mullikin
13. Birthplace: Talbott Co. Md.

MOTHER
14. Maiden name: Grace A. McNeil
15. Birthplace: Balto. Md.

16. Informant: William P. Johns
Address: 5705 Edmondson Ave

17. Burial (Burial, cremation, or removal, Which?) Date thereof 2/3/47 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: " Md.

18. Funeral director: William Cook Inc
Address: 1217 St. Paul St.

19. 2/3 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31st 1947 at 10:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1947, to January 31 1947 and that I last saw h.. alive on January 30 1947

Immediate cause of death	DURATION
Carcinoma of uterus	about 3 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Geo J. Gore M.D. (M. D. or other)
Address: Baltimore, Md Date signed: Feb 1 1947

~~DUPLICATE~~

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (179-J)

CERTIFICATE OF DEATH

00255 P

Reg. Dist. No. 043

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 hours 5 minutes
Hospital, Institution, or street address where death occurred:
V.A. Ft. Howard, Maryland
How long in hospital or institution? 14 hours 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 610 Brune Street
(If rural, give LOCATION)
2.(a) If veteran, name war WW-2

3.(a) FULL NAME HERBERT W. JOHNSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife Single
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-17-1917

8. AGE: Years	Months	Days	If less than one day
29 ~~38~~	5	22	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name William Johnson
13. Birthplace Calvert County, Md.
MOTHER 14. Maiden name Henrietta Johnson
15. Birthplace Calvert County, Md.
16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof 1 | 13 | 47 (month) (day) (year)
Cemetery or crematory National Cemetery, Balto. Md.
Location Baltimore, Maryland
18. Funeral director Isaiah Brown
Address 108 W. Montgomery St. Balto. Md.
19. 1-13 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 19 47, at 10:05A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 8 19 47 to January 9 19 47 and that I last saw him alive on January 9 19 47

	DURATION
Immediate cause of death ACUTE CLOUDY SWELLING OF KIDNEYS WITH UREMIA	9 days
Due to Sulfonomide Poisoning(?)	9 days
Due to Given for urethral discharge. Medication given prior to admission. Cerv.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results Substantiated above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

RMB
23. SIGNATURE ROBERT M. CULLISON, M.D. CLIN. DIR. M. D. or other
Address V.A.H. Ft. Howard, Md. Date signed 1-9-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44 — 00256

1. PLACE OF DEATH:

County V.A.H. Fort Howard,

City or town Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:
VAH Fort Howard, Maryland

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County

City or town Norfolk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1012 Edwards Street
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME ARRIS JOYNER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Mrs. Hattie Joyner

2/9/1895 6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 2/9/1895

8. AGE: Years	Months	Days	If less than one day
51	11	3	hrs. min.

9. Birthplace Greenville, North Carolina
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER — 12. Name George Joyner -deceased

13. Birthplace Greenville, N.C.

MOTHER — 14. Maiden name Florence Ebron -deceased

15. Birthplace Greenville, N.C.

16. Informant Clin. Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-47 (month) (day) (year)

Cemetery or crematory Baltimore National

Location Frederick Ave. Belle City

18. Funeral director 502 Madison Ave

Address Charles R. Fax

19. (Date received by registrar) 1/14/47 A.W. Hedrick Bro.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 19 47, at 4:21 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 19 47, to January 12 19 47 and that I last saw him alive on January 12 19 47

Immediate cause of death	DURATION
Fibrocaseous tuberculosis	2-1/2 Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison M. D. or other

R.M. CULLISON, M.D. CLIN. DIR.

Address V.A.H. FT. HOWARD, MD. Date signed 1-19-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00257

CERTIFICATE OF DEATH

Reg. Dist. No. 441

1. PLACE OF DEATH:
County Baltimore
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 500 Eastern Blvd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 500 Eastern Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Juliano

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married

6.(b) Name of husband or wife Amelia (Bokene)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct - 17 - 1884

8. AGE: Years	Months	Days	If less than one day
62	3	1	....hrs. ....min.

9. Birthplace Italy (town, county, and state)
10. Usual occupation Grocer
11. Industry or business Retired
FATHER 12. Name Frederick Juliano
13. Birthplace Italy
MOTHER 14. Maiden name Anna ?
15. Birthplace Italy
16. Informant Mrs. Amelia Juliano
Address 500 Eastern Blvd
17. Burial Date thereof Jan - 22 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Oak Lawn Cem.
Location Eastern Blvd.
18. Funeral director John G. Connelly
Address 418 Eastern Blvd.
19. Jan 21st 1947 John G. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18 1947 at 7" M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May - 1937 to Jan 7 1947
and that I last saw h... alive on Jan 6 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. Kruger M. D. or other
Address 500 E Baltimore Blvd Date signed 1/21/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-05

2-04440 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00258

Reg. Dist. No. 33

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Balto
City or town: Boring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto
City or town: Boring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Kelbaugh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: George T Kelbaugh
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 9 - 1851

8. AGE:

Years	Months	Days	If less than one day
95	3	27	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Nicholas Lowe
13. Birthplace: Maryland

MOTHER
14. Maiden name: Nancy Lockard
15. Birthplace: Maryland

16. Informant: Miss Lillian Kelbaugh
Address: Boring, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 8 47 (month) (day) (year)
Cemetery or crematory: Pleasant Grove
Location: Balto Co Md

18. Funeral director: Edward Tipton
Address: Hampstead Md

19. Jan 6 1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/6/47 19..... at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/20 19..... to 1/6/47 19.....
and that I last saw her alive on 1/6/47 19.....

Immediate cause of death: Myocardiotis — Chronic decompensation

DURATION
5 Yrs

Due to: hypertension

Due to: arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: M. D. or other
Address: Reisterstown Md Date signed 1/6/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. ★Bc 00259

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or Institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1226 Bonaparte Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3.(a) FULL NAME JOHN GILMORE KELLY

3.(b) Social Security Number 214-24-3051

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Julia Kelly

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 9-22-88

8. AGE:	Years	Months	Days	If less than one day
	58	3	14	..... hrs. ..... min.

9. Birthplace Keyser, W. Va.
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Dennis Kelly

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Gilmore

15. Birthplace Unknown

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/9/47 (month) (day) (year)

Cemetery or crematory Baltimore National

Location Baltimore, Maryland

18. Funeral director HENRY SANDER & SONS, INC.

Address NORTH AVE. & BROADWAY

19. 1/9 (Date rec'd by registrar) 19 47 A. L. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1947 at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 5, 1947, to January 6, 1947 and that I last saw h... im ...alive on January 6, 1947

Immediate cause of death	DURATION
Rupture of emphysematous bleb; pneumothorax, right	1 day
Due to	
Due to	
Other conditions Fibroid pulmonary tuberculosis and Purulent bronchitis	20 Yrs. 2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison M. D. or other

R. M. CULLISON, M.D. CLIN. DIR.

Address V.A. Hosp., Ft. Howard, Md. Date signed 1-6-47

Evidence for the change of date of birth is shown on G 108 2/ 3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00260

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Balto Co
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 yrs.
Hospital, Institution, or street address where death occurred:
21 DELHEY. AVE.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto.
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No 21 Delhey ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MERVIN E KIMMELSHUE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED.

6.(b) Name of husband or wife: LAURA V KIMMELSHUE

7. Birth date of deceased (mo., day, yr.): ~~9/23/1891~~ 9/23/1890

6.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56				

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: RETIRED OFFICER

11. Industry or business: BALTO CO 8000

MOTHER / FATHER

12. Name: Geo W KIMMELSHOE

13. Birthplace: ?

14. Maiden name: MARY E MOSHER

15. Birthplace: ?

16. Informant: LAURA V KIMMELSHUE
Address: 21 DELHEY AVE

17. Burial, cremation, or removal. Which?: BURIAL. Date thereof: 1/28/47 (month) (day) (year)
Cemetery or crematory: SALEM CEMETERY
Location: CATONSVILLE MD

18. Funeral director: MACNABB FUNERAL
Address: CATONSVILLE MD

19. 1-28-1947 (Date rec'd by registrar) Harry E Mylling Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan - 25 1947, at 4:00 A.M.

I CERTIFY, that death occurred on the date above stated; that I attended deceased from July - 18 1946 to Jan - 24 1947 and that I last saw h.im alive on Jan - 22 - 1947

Immediate cause of death	DURATION
Chronic Myocardial Degeneration	
Due to: With Oedema	1-2- yrs.
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: ns.

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Manner of injury: — Injured at work?

23. SIGNATURE: S. Lloyd Johnson M. D. or other
Address: Catonsville Date signed 1-27-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13a

00261

Reg. Dist. No. 30

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 642 North Bend Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Minna Kirby

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Harry C. Kirby
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 10, 1881

8. AGE: Years	Months	Days	If less than one day
65	7	12	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Home Duties
11. Industry or business

FATHER
12. Name Louis C. Horn
13. Birthplace Germany

MOTHER
14. Maiden name Frances Spender
15. Birthplace Germany

16. Informant Mrs Frances A. Harrington
Address 642 North Bend Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 24, 1947 (month) (day) (year)
Cemetery or crematory London Park
Location Baltimore
18. Funeral director Frederick A. Cole
Address 1200 N. Lombard St.

19. Jan 24 1947 (Date rec'd by registrar) A. W. Yelvis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1947, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18 1947 to Jan. 22 1947 and that I last saw h[illegible] alive on Jan. 12 1947

Immediate cause of death — Myocardial Renal Disease — DURATION (3)
Due to Arterio Sclerosis — 1-2 Weeks
Due to — Months
Other conditions —
(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.
Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury No Injured at work?

23. SIGNATURE S. Lloyd Johnson M.D.
M. D. or other
Address Catonsville Date signed 1-23-47

00262 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-a

CERTIFICATE OF DEATH

Reg. Diat. No. ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 17 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ....

City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)

Street No. Box 31, Wildwood Beach
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: CHARLES R. KIRK

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eleanor C. Kirk

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): 6-14-1894

8. AGE:

Years	Months	Days	If less than one day
52	7	2	.... hrs. .... min.

9. Birthplace: New York, N. Y.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: ....

FATHER
12. Name: Christie Kirk
13. Birthplace: Denmark

MOTHER
14. Maiden name: Eva Neville
15. Birthplace: England

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-21-47 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore-Maryland

18. Funeral director: Ellsworth Arnacost

Address: 3911 Liberty Heights Ave

19. 1/18 (Date rec'd by registrar) 19 47 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16, 19 47 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30, 19 46, to January 16, 19 47 and that I last saw him alive on January 16, 19 47

Immediate cause of death	DURATION
Shock following transurethral resection of median lobe of prostate	12 Hrs.
Due to Benign prostatic hypertrophy, lateral lobes and median bar. Cystoscopy	
Due to	
Other conditions: Calcified fecalith of appendix; small appendiceal abscess	1 Month

(Include pregnancy within 3 months of death) No operation.

Major findings of operations: .... Date of op. ....

Autopsy results: Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other

R.M. CULLISON, M.D. CLIN. DIR.

Address: V.A. FT. HOWARD, MD. Date signed: 1-27-47

STATE OF MARYLAND—CERTIFICATE OF DEATH

00263

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

1. PLACE OF DEATH 1945

County Balto. Registration Dist. No. 74

Village or City Essex No. 616 Eastern Ave St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Ellen Kravitz

(a) Residence: No. 616 Eastern Ave St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Fem.	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) ~~Dec~~ 27/1946

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	3	—	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. none

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. none

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Essex Md. (State or country)

FATHER

13. NAME Hyman Kravitz

14. BIRTHPLACE (city or town) Balto Md. (State or country)

MOTHER

15. MAIDEN NAME Ruth Shapiro

16. BIRTHPLACE (city or town) Balto. Md. (State or country)

17. INFORMANT Hyman Kravitz (Address) 616 Eastern Ave Essex

18. BURIAL, CREMATION, OR REMOVAL Place Balto. Hebrew Data Jan 29, 1947

19. UNDERTAKER Sol Levinson Bro (Address) 1124 W North Ave

20. FILED Jan 27, 1947 John D. Carroll Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan 27, 1947 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1947, to Jan 27, 1947

I last saw her alive on dead, 19—; death is said to have occurred on the date stated above, at 4 30 P. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Suffocation by aspiration in Crib of Bronchus.	

Other **Contributory Causes** of importance:

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury —, 19—

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or In PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) M. McLaurine M. D. M. D.

(Address) Dept. Medical Examiner Westminster Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	**Date of onset**	**The principal cause of death and related causes of importance were as follows:**	**Date of onset**
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		**Other contributory causes of importance:**	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

1520

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a * 00264

Reg. Dist. No. 43

1. PLACE OF DEATH:

County Balto.

City or town Fullerton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5-4 yrs.

Hospital, institution, or street address where death occurred: Whitemarsh Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. Whitemarsh Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Catherine Kreit

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife John Kreit

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 6th 1857

8. AGE: Years	Months	Days	If less than one day
90		11	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation at home

11. Industry or business

MOTHER FATHER

12. Name John Rau

13. Birthplace Germany

14. Maiden name —

15. Birthplace —

16. Informant E. J. Kreit

Address Whitemarsh Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 21 47 (month) (day) (year)

Cemetery or crematory St. Josephs

Location Balto. Co. Md.

18. Funeral director Carmen Funeral Home

Address 7401 Belair Rd.

19. Jan 19 1947 (Date rec'd by registrar) Mrs. A. L. Redsmith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17th 1947, at 4:30 P.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from May 22 1946, to Jan. 17 1947.

and that I last saw h alive on Jan 17 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to Cerebral Arterio-sclerosis	
Due to Infirmity of Old Age	
Other conditions Age 90 yrs. Under Care 4 yrs.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. W. Megarden M. D. or other

Address 1532 E. 33rd St. Date signed 1/14/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00265

1. PLACE OF DEATH:

County: Baltimore

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:
1218 64th Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1218 64th Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: STANISLAWA KWIATKOWSKA

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Stanislaus

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Unknown 1888

8. AGE: Years	Months	Days	If less than one day
59			..... hrs. ..... min.

8. Birthplace: Poland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Martin Topelski

13. Birthplace: Poland

MOTHER — 14. Maiden name: Katherine ?

15. Birthplace: Poland

16. Informant: Mr. Stanislaus Kwiatkowski

Address: 1218 64th Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/30/47 (month) (day) (year)

Cemetery or crematory: St. Stanislaus

Location: Mt. Carmel Road

18. Funeral director: M. F. Sadowski & Sons

Address: 1808 Eastern Avenue.

19. Jan 28 1947 (Date rec'd by registrar) A. W. Wedrich J.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 26 1947 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1946 to Jan 1947 and that I last saw h...e alive on Jan 16 1947

Immediate cause of death	DURATION
Arteriosclerotic Cerebrovascular Disease	
Due to	
Due to	
Other conditions: Chronic Nephritis.	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op. Dec 1946

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Gordon M.D.
M. D. or other

Address: 3400 E. Baltimore Date signed: 1/28/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

916

00266

CERTIFICATE OF DEATH

Reg. Dist. No. 357

1. PLACE OF DEATH:

County: Baltimore

City or town: Maryland Line

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Maryland Line

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alverdia Leib

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow.

6.(b) Name of husband or wife: John Leib

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): December 12, 1862

8. AGE:

Years	Months	Days	If less than one day
84	1	8	...hrs. ...min.

9. Birthplace: Baltimore Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home.

FATHER

12. Name: James Fletcher

13. Birthplace: Md.

MOTHER

14. Maiden name: Mary Baker

15. Birthplace: Md.

16. Informant: John Leib

Address: Maryland Line, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Jan. 24 1947 (month) (day) (year)

Cemetery or crematory: New Market

Location: Maryland Line, Md.

18. Funeral director: Jacob Hartsock Sons

Address: New Freedom, Pa.

19. Jan 22 1947 (Date rec'd by registrar)

Edwin J. Fuller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20, 1947, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 21 1946, to Jan. 20 1947 and that I last saw her alive on Jan. 17 1947

Immediate cause of death	DURATION
(a) Coronary Endocarditis	
Due to: Jan 17 - '47	
" 20 - '47	
Due to:	
Other conditions: Senile Dementia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. C. Dunmire M. D. or other

Address: New Freedom, Pa. Date signed 1-21-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2-352 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1176 BC

00267 8

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One day

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? One day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 404 E. Preston Street
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Harvey Love

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Loretta Love

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): 8-21-90

8. AGE: Years	Months	Days	If less than one day
56	4	22	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business:

FATHER
12. Name: Benjamin Love
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Julia Carroll
15. Birthplace: Baltimore, Maryland

16. Informant: Clin. Records, Vets. Adm. Hospital
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: 6501 Frederick Avenue, Baltimore, Md.

18. Funeral director: Miedefeld and Sons
Address: Greemont Avenue & 22nd Street

19. Jan 14 19 47 (Date rec'd by registrar) R. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 19 47 at 6:15p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 11 19 47 to January 12 19 47 and that I last saw him alive on January 12 19 47

Immediate cause of death	DURATION
GENERALIZED PERITONITIS	Unknown
Due to: Perforated duodenal ulcer	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Generalized peritonitis due to perforated duodenal ulcer Date of op. 1-12-47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Morris E. Krucoff
MORRIS E. KRUCOFF, M.D. M. D. or other
Address: Fort Howard, Md. Date signed 1-12-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

49a

00268

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Balto.

City or town Stevenson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

Valley Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Stevenson

(If outside city or town limits, write RURAL and give nearest town)

Street No. Valley Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edith M. Maddox

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Harry E. Maddox

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 5th 1884

8. AGE: Years	Months	Days	If less than one day
62	8	13	..... hrs. ..... min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER

12. Name Samuel Biddison

13. Birthplace Balto. Co. Md.

MOTHER

14. Maiden name Alice Hahn

15. Birthplace U.S.

16. Informant H. E. Maddox

Address Valley Rd. Stevenson

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 22 47 (month) (day) (year)

Cemetery or crematory Oak Lawn Cem

Location Balto. Md

18. Funeral director Lansdale Funeral Home

Address 7401 Belair Rd.

19. 1-18 1947 (Date rec'd by registrar) Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18th 1947, at 1.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 23 1946 to Jan 18 1947 and that I last saw her alive on Jan 18 1947

Immediate cause of death	DURATION
Carcinoma of right ovary and general	1 yr +
Due to Carcinomatosis	
Due to Advanced Cancer	1 yr
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E E Nichols M. D. or other

Address Pikesville 8 Md Date signed 1-18-47

VS A15 9-45 15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 00269 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Reisterstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Mt. Pleasant
Stay in hospital or inst. (yrs., or mos., or days) 1 Month 20 Days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D. C. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1411 Saratoga Ave. N.E.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Nathan Maisel

3. (b) Social Security Number 578-18-1422

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife: Hannah Maisel
6(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): September 6, 1912

8. AGE:

Years	Months	Days	If less than one day
34	3	19	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business

FATHER
12. Name: Harry Maisel
13. Birthplace: Hungary.

MOTHER
14. Maiden name: Dora Cohen
15. Birthplace: Russia.

16. Informant: Hannah Maisel
Address: 1411 Saratoga Ave. N.E. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-2-47 (month) (day) (year)
Cemetery or crematory
Location: Windsor Mill Road
18. Funeral director: Jack Lewis Inc.
Address: 1439 E Balto St

19. 1-2-47 (Date rec'd by Registrar) Registrar

1-35

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1, 1947 at 2:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 11, 1946 to Jan. 1, 1947 and that I last saw h~~im~~ alive on Jan. 1, 1947.

	DURATION
Immediate cause of death: Myocardial Collapse	
Due to: Myocardial Insufficiency	2 Days
Due to: Pulmonary Tuberculosis	8 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Albert J. Shrei M.D.
M. D. or other
Address: Reisterstown, Md. Date signed 1/1/47

00270

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 330

1. PLACE OF DEATH:
County: Balto.
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Liberty Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Liberty Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Estelle Malley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow.

6.(b) Name of husband or wife: John H. Malley.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov 5, 1882

8. AGE: Years	Months	Days	If less than one day
64	2	22	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
12. FATHER — Name: Franklin Carneal
13. FATHER — Birthplace: Va.
14. MOTHER — Maiden name: Alice G. Neal
15. MOTHER — Birthplace: Md.
16. Informant: John H. O'Malley.
Address: 3020 Fisby St
17. Burial (Burial, cremation, or removal, Which?) Date thereof Jan 31/47 (month) (day) (year)
Cemetery or crematory: Ballendree
Location: North Ave
18. Funeral director: Cromwell & Donovan
Address: 3615-17 Chestnut Ave
19. 1-29-1947 (Date rec'd by registrar) Mary B. Elvis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27 19 47, at 11:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-28-'47 19 to 1-28-'47 19 and that I last saw her alive on not seen alive 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hour
Due to Hypertensive C.-V. Disease	5 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? NONE (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Dr. D. D. Eagles Med. Exam. M. D. or other
Address: Reisterstown, Md. Date signed: 1-28-'47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00271

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one Month.

Hospital, institution, or street address where death occurred: Opitz Home

How long in hospital or institution? one Month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: [redacted]

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 43 South Pulaski Street

(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3. (a) FULL NAME: ANNIE M. MARINER

3. (b) Social Security Number: [redacted]

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife: Albert G. Mariner

6.(c) If alive, give age: Dec. years

7. Birth date of deceased (mo., day, yr.): October 1st. 1866

8. AGE:	Years	Months	Days	If less than one day
	80	3	19	..... hrs. ..... min.

9. Birthplace: West Morland County Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER 12. Name: Ransal Gutridge

13. Birthplace: Virginia

MOTHER 14. Maiden name: Elizabeth Anthony

15. Birthplace: Virginia

16. Informant: Mrs. Myrtle O. Yakel

Address: 2122 West Saratoga Street

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) Jan. 23, 1947

Cemetery or crematory: Mount Olivet Cemetery

Location: Baltimore, Maryland

18. Funeral director: C. B. Kippert & Son. F.B. WIPPERT & SON..

Address: 1300 Eutaw Place..17

19. (Date rec'd by registrar) 1-22-47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 January 47 19..... at 4:P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 19 46 to Jan 20 19 47 and that I last saw her alive on Jan 19 19 47

Immediate cause of death: Arteriosclerotic Heart Disease — DURATION: 2 weeks

Due to:

Due to:

Other conditions: Overcome with Gas in Dec 1946: She had fully recovered from the effects of the gas, on day of discharge from hospital.

(Include pregnancy within 3 months of death)

Major findings of operation: ..... 21.Date of op. C.O.D.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J M Collins M.D.

Address: 352 Frederick Ave. M. D. or other

Date signed: 1/22/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland —
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 442 — 3rd Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country V

3 (a) FULL NAME Ross Paige Marks

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 23-1925

8. AGE: Years	Months	Days	If less than one day
21	11		hr. min.

9. Birthplace Chatham County - N. C. (Town, county and state)

10. Usual Occupation Weather stripper

11. Industry or business

FATHER
12. Name Edward S. Marks
13. Birthplace Chatham Co. North C.

MOTHER
14. Maiden Name Mollie Paige
15. Birthplace Harnett County N. C.

16 (a) Informant Vernon S. Marks
(b) Address 308 Glascock - N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13-47 (month) (day) (year)
(c) Cemetery or crematory Mont Lawn Memorial
Location Raleigh - N. C.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) 1-13 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1947 at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Possibly exposure

Due to (decomposition of body too far advanced to be certain)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner
Date signed 1/6/47

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Baltimore

City or town: Rogers Forge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Armacost Nursing Home-812 Regester Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County: Montgomery

City or town: Wayne
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Fletcher Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME Mary ELLA Maxfield

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	WIDOW

6.(b) Name of husband or wife: FRANK H. MAXFIELD

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JULY 15, 1861

8. AGE:

Years	Months	Days	If less than one day
85	5	17	..... hrs. ..... min.

9. Birthplace: EAST BOSTON, MASS.
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER
12. Name: STEPHEN GROVER
13. Birthplace: MASS.

MOTHER
14. Maiden name: ELIZA HALL
15. Birthplace: MASS.

16. Informant: MRS. FRANK B. TOMPKINS
Address: MALVERN AVE., RUXTON

17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof 1/2/47 (month) (day) (year)

Cemetery or crematory: FORESTDALE CEM.
Location: MALDEN, MASS.

18. Funeral director: WM. J. TICKNER & SONS
Address: BALTO., MD.

19. 1/2 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 2 1947 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 1946 to Jan 2 1947 and that I last saw h.e alive on Dec 29 1946.

	DURATION
Immediate cause of death: Heart disease,	Unknown
progressive glaucoma	1 yr +
Due to: Cerebro-vascular disease	Unknown
Due to: Senile changes	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Rollin L. Hudson M.D.
M. D. or other

Address: Towson Md Date signed 1/2/47

1-25-2-5-10-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83L *18 — 00274 K4 — Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Md.

How long in hospital or institution? 36 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 729 W. Fayette St.
(If rural, give LOCATION)

2.(a) If veteran, name war: Retired

3.(a) FULL NAME: EDWARD MAY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2-2-1870

8. AGE:

Years	Months	Days	If less than one day
76	11	22	hrs. min.

9. Birthplace: Ella Wisconsin
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-27-1947 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore Md.

18. Funeral director: Flynn & Flannery

Address: 1476 Light St.

19. 1/27 (Date rec'd by registrar) 19 47 R. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1947 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 1947, to January 24 1947 and that I last saw him alive on January 24 1947

	DURATION
Immediate cause of death: CEREBRAL THROMBOSIS	2 mos.
Due to: Hypertension Generalized	
Arteriosclerosis	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob F. Katz m.d.
M. D. or other

Address: V.A.H. Fort Howard, Md. Date signed 11-24-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1937 00275 Reg. Dist. No. 37

1. PLACE OF DEATH:
County Baltimore
City or town Butler
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto.
City or town Butler
(If outside city or town limits, write RURAL and give nearest town)
Street No. Butler Road
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Florence May Merryman

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1873

8. AGE: Years 74 | Months — | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual occupation Homemaker
11. Industry or business

FATHER
12. Name John E. Merryman
13. Birthplace Balto Co, Md

MOTHER
14. Maiden name Frances Cromwell
15. Birthplace Balto Co Md.

16. Informant Miss Sarah A Stevenson
Address Butler, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 2, 1947 (month) (day) (year)
Cemetery or crematory Bosley's
Location Sparks, Md.

18. Funeral director Landon M. Bosley
Address Sparks Md.

19. 2-1 47 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1947 at 8:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-25-'47 1947, to 1-30-'47 1947
and that I last saw her alive on 1-30-'47 1947

Immediate cause of death	DURATION
Cardiac Decompensation	1 wk.
Due to arteriosclerosis	5 yrs.
Due to Hypertensive C-V Disease	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
NONE Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? NONE (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. D. Caples, M. D. (M. D. or other)
Address Reisterstown, Md. Date signed 1-31-'47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

L-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d ★ 00276

Reg. Dist. No. 370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Ashland (Cockeysville P.O.)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Ashland (Cockeysville P.O.)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Annie Virginia Menyman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife Wm. F. Menyman
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 23 1869

8. AGE: Years	Months	Days	If less than one day
77	8	—	hrs. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Bull
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden name —
15. Birthplace

16. Informant Robt. Benj. Menyman
Address Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-27-47 (month) (day) (year)
Cemetery or crematory Pine Grove
Location Rayville, Balto Co. Md.
18. Funeral director Landon M. Brooks
Address Sparks, Md.

19. — 1-24 19 47 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 19 47 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 16 19 46 to Jan 23 19 47 and that I last saw h— alive on 1/23 19 47.

Immediate cause of death	DURATION
Myocarditis	5 Yrs.
Due to Arteriosclerosis	
Due to	
Other conditions Capillary Bronchitis	1 wk.

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wilmer C. Ensor M. D. or other
Address Cockeysville Md. Date signed 1/24/47

I-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00277

Reg. Dist. No. 38

P

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since June 7, 1929
Hospital, Institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.
How long in hospital or institution? Since June 7, 1929

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 3315 Edmondson Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ernest John Michel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mildred A. Michel
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 7, 1888

8. AGE: Years: 58 Months: 6 Days: 21 If less than one day: hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Laborer - Garden
11. Industry or business

FATHER 12. Name	Ernest Henry Michel
FATHER 13. Birthplace	Baltimore Md
MOTHER 14. Maiden name	Emma Louise Stewart
MOTHER 15. Birthplace	Baltimore Md

16. Informant: Personal History, Hospital Records
Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 2/1/47 (month) (day) (year)
Cemetery or ~~crematory~~: Balto
Location: Md.
18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St.

19. 1/29 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 1947 at 10:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1929 to January 28 1947 and that I last saw him alive on January 28 1947

Immediate cause of death	DURATION
Pulmonary tuberculosis	2 yrs
Due to	June 1926
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W A Bridges M. D. or other
Address: Towson 4, Maryland Date signed 1-28-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52a

00278

CERTIFICATE OF DEATH

Reg. Dist. No. 301

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Balto Co.

City or town: Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, Institution, or street address where death occurred:
610 Edmondson ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)

State: Md County: Balto

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 610 Edmondson ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Milton W W Miles.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife: Adeline W Miles

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): July 18 1890

8. AGE: Years: 57. Months: 0 Days: If less than one day: hrs. min.

9. Birthplace: Maryland.
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: Contractor

FATHER
12. Name: William H Miles.
13. Birthplace: Maryland

MOTHER
14. Maiden name: Carbel L Cator
15. Birthplace: Maryland.

16. Informant: Adeline W Miles.
Address: 610 Edmondson ave

17. Burial
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: London Park.
Location: Balto City

18. Funeral director: Edgar J MacNabb.
Address: Catonsville Md.

19. 1-28-47 Harry L Fuller
(Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 21 1947, at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 14 1945 to Jan. 21 1947 and that I last saw him alive on Jan 21 1947

Immediate cause of death	DURATION
Uremia	1 day
Due to: Nephritis	2 mos.
Due to: Hypernephroma Left Kidney	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo E Elliott M. D. or other

Address: Catonsville 28 Md. Date signed: 1-22-47

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01027

Reg. Dist. No. 337

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural near Freeland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Baltimore.
City or town: Rural - Freeland.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 mi. East of Freeland.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Gloria Jean Miller.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 21, 1946.

8. AGE:

Years	Months	Days	If less than one day
	3	10	____ hrs. ____ min.

9. Birthplace: Freeland, Md. R.D. (Town, county, and state)
10. Usual occupation:
11. Industry or business:

MOTHER / FATHER
12. Name: Stephen Miller.
13. Birthplace: Stewartstown, Pa. R.D.
14. Maiden name: Jean Wilson.
15. Birthplace: Hunger ford, Pa.

16. Informant: Stephen Miller
Address: Freeland, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Febr. 2, 1947 (month) (day) (year)
Cemetery or crematory: New Freedom
Location: New Freedom, Pa.

18. Funeral director: Jacob Harlen Leib
Address: New Freedom, Pa.

19. Feb 1 1947 (Date rec'd by registrar) Edwin L. Frailey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31, 1947 at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__ and that I last saw h alive on arrival 19__

Immediate cause of death	DURATION
Acute Cardeac failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. Ng. France M. D. or other
Address: Carlton, Md. Date signed 1/3/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

2-350 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Lundale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 3507 Louth St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Lundale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3507 Louth St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George T Minner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Annie L Minner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 13, 1872

8. AGE: Years	Months	Days	If less than one day
74	0	29	..... hrs. ..... min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name John Minner

13. Birthplace West Virginia

MOTHER

14. Maiden name Mary

15. Birthplace West Virginia

16. Informant George L Minner

Address 3507 Louth St Lundale Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-13-47 (month) (day) (year)

Cemetery or crematory Gunts

Location Sykesville West Virginia

18. Funeral director Wm Foote Sons

Address 217 E Saint St

19. 1-13 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 19 47 at 6 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11, 19 47 to Jan 12 19 47

and that I last saw h... alive on Jan 12 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to Arteriosclerosis	10 yrs
Due to Myocarditis	6 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

28. SIGNATURE David H. Andrews M.D. M. D. or other

Address 7 Kirkwood Rd Lundale Md Date signed 1/13/47

SPECIAL CASE: PHOTOSTAT OR COPY BOTH SIDES, PLUS DOCTOR'S LETTER, WHEN ISSUING CERTIFIED COPIES. AWH (LL) 2-12-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1024 00280

Reg. Dist. No. 38 1

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Baltimore County Police Station
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State Maryland County Baltimore
City or town Towson Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 200 Maryland Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR = World War II

3. (a) FULL NAME John Robert Morris, Jr. | 3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife None
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 24, 1927

8. AGE: Years	Months	Days	If less than one day
19	11	8	hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Retired-
11. Industry or business U.S.Army Air Corp

FATHER
12. Name John Robert Morris, Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Elizabeth Gale
15. Birthplace Baltimore, Md.

16. Informant Mrs. John R. Morris, Sr.,
Address 200 Maryland Ave., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3, 1947 (month) (day) (year)
Cemetery or crematory Mt. Maria Cemetery
Location Towson, Maryland
18. Funeral director John Burns' Sons
Address Towson, Maryland

19. Jan. 2, 1947 (Date rec'd by registrar) Carroll Van Hook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1947, at 5:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death. Suffocation, accidental fire — DURATION 1/1/47

Due to

Due to

Other conditions See over

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accidental fire Date of 1/1/47
Where did injury occur? Towson (City or town) Baltimore (County) Md (State)
Injured at home, farm, industry, public place (where?) Police Station (address)
Means of injury Suffocation in accidental fire Injured at work? No

T32

23. SIGNATURE Rollin E. Hughes M.D. D.M.E.
M. D. or other
Address Towson Md Date signed 1/1/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK correct age is especially important. Physicians: please

MARGIN RESERVED

Attached letter from Dr. Rollin C. Hudson anticipates that the entries under "burns" and "alcoholism" were not based upon adequate evidence and should be deleted from the death certificate.

Feb. 11/47

R. W. Radcliffe
Asst. State Registrar

1-25

2-380-1-10

TELEPHONE TOWSON 32

ROLLIN C. HUDSON, M. D.
606 BALTIMORE AVENUE
TOWSON, MD.

4

Feb 10, 1947

Dr. A. W. Hendrich
Maryland State Dept. Health.

FEB 11 1947

Dear Dr. Hendrich, Dr. Howard Malden talked with Mr. Thos. Biddison, attorney on the case of John Robert Morris Jr. who died of suffocation Jan 1, 1947 in the police station fire.

He and I believe the death certificate is properly: Death by suffocation.

The statements of alcoholism were made by the police and since not verified by blood or spinal fluid tests, do not belong on the certificate.

The burns were evidently received after suffocation and are not properly a cause of death.

Sincerely,
Rollin C. Hudson M.D. D.M.E.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 00281

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Lansdowne (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Lansdowne (If outside city or town limits, write RURAL and give nearest town)
Street No.: 150 Howard Ave. (If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Samuel F. Morris

3.(b) Social Security Number: 220-05-5130

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 25-1870

8. AGE: Years: 76 | Months: 6 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Auditor
11. Industry or business: Baltimore Life Ins Co

FATHER
12. Name: William E. Morris
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mary E. Allough
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Edna Sisler
Address: 150 Howard Ave Lansdowne

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 1-47 (month) (day) (year)
Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Md.

18. Funeral director: F. B. Hufnagel & Son
Address: 800 Eutaw Place

19. 2/1/47 (Date rec'd by registrar) C W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29- 1947, at 6:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1946, to Jan 28 1947
and that I last saw h. alive on Jan 28 1947

Immediate cause of death	DURATION
Arteriosclerotic cardio-vascular Disease	?
Due to:	
Due to:	
Other conditions: Left Cerebral Hemorrhage	June 1946

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work?

23. SIGNATURE: Carey Rosting M. D. or other
Address: 1326 W Lombard St Date signed: 1/30/47

Reid V.S.
2/1/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

952 00282

Reg. Dist. No. 401

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Baltimore Co.
City or town: Kingsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Kingsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Chester A. Morrison

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Nov 29. 1888.

8. AGE: Years: 58 Months: 1 Days: 26 If less than one day: ... hrs. ... min.

9. Birthplace: Harford Co. Md.
(Town, county, and state)

10. Usual occupation: Electrician.

11. Industry or business

FATHER
12. Name: Wm. J. Morrison
13. Birthplace: Hahford Co. Md

MOTHER
14. Maiden name: Hannah E. Nelson
15. Birthplace: Harford Co. Md.

16. Informant: Harry N. Morrison
Address: Gambrills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28 1947 (month) (day) (year)
Cemetery or crematory: Mt. Vernon
Location: Whitford, Md.

18. Funeral director: Ruhl P. Harkins
Address: Delta, Pa.

19. Jan 27 1947 (Date rec'd by registrar) C. T. Arthur Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25 1947 at 2.05 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2 1943 to Jan. 25 1947 and that I last saw h... alive on January 25 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	5 days
Due to: Cerebral Arteriosclerosis	7
Due to:	
Other conditions: Arteriosclerotic Renal Disease (Include pregnancy within 3 months of death)	4 yrs

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. B. Lora M.D.
M. D. or other
Address: York Md Date signed 1/25/47

1-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00283

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 month
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 426 Overbrook Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Edward Mullinix

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Katie Mullinix
6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): May 19, 1863

8. AGE:

Years	Months	Days	If less than one day
83	7	18	...hrs. ...min.

9. Birthplace: Howard Co. Maryland
(Town, county, and state)
10. Usual occupation: Carpenter (retired)
11. Industry or business:

MOTHER FATHER
12. Name: Charles T. Mullinix
13. Birthplace: Maryland

MOTHER
14. Maiden name: Polly Penn
15. Birthplace: Maryland

16. Informant: Mrs. Katie Mullinix
Address: 426 Overbrook Rd. Catonsville Md

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof: 1-10-47 (month) (day) (year)
Cemetery ~~or crematory~~: Howard Chapel
Location: Long Corner Howard Co Md

16. Funeral director: E. M. Walter
Address: Ellicott City Md.

19. 1-8 19 47 (Date rec'd by registrar)
Harry D. Mullinix Registrar
Carpenter

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 7 19 47, at 3 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 19 46, to Jan 7 19 47
and that I last saw him alive on Jan 7, 1947 19

Immediate cause of death	DURATION
Myocardial insufficiency	3 wks.
Due to Arteriosclerosis	?
Cardio Vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. P. Vandenberg M. D. or other
Address: 4818 Edmondson Ave Date signed: 1/7/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00284

94a ★

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH: Baltimore

County .....

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

309 Willow Ave.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

Street No. 309 Willow Ave. (If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Byron C. Myers

3.(b) Social Security Number 216-07-1036

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Nellie H. Myers 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 26th, 1880

8. AGE: Years	Months	Days	If less than one day
67			..... hrs. ..... min.

9. Birthplace Mass. (Town, county, and state)

10. Usual occupation Sand Bobbler

11. Industry or business Silversmith

FATHER 12. Name — —

13. Birthplace

MOTHER 14. Maiden name Houghton

15. Birthplace —

16. Informant Nellie Myers

Address 309 Willow Ave.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1 25 47 (month) (day) (year)

Cemetery or crematory Ogdensburg, Cem.

Location Ogdensburg N. Y.

18. Funeral director Lassahn Funeral Home

Address 7401 Belair Road

19. Jan 25 1947 (Date rec'd by registrar) Mrs. A. L. Reifsnider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1947 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1946, to Jan 24 1947 and that I last saw h— alive on Jan 24th 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 week
Due to	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Edward Benson M. D. or other

Address 10 Overlea Ave Date signed 1/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

00285 430

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:
Old Philadelphia Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. Old Philadelphia Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Philip J. Naimaster

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife Margaret E. Naimaster

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 15, 1872

8. AGE: Years	Months	Days	If less than one day
74	11	13	..... hrs. ..... min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name George Naimaster

13. Birthplace Unknown

MOTHER 14. Maiden name Sally Coons

15. Birthplace Unknown

16. Informant Mrs. Dohler,

Address Old Phila. Rd. Balto. 6, Md.

17. burial Date thereof Jan. 31 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Lutheran Cemetery

Location Stemmers Run, Md.

18. Funeral director Lauchle Funeral Home

Address 7401 Belair Road

19. Jan 29 1947 Mrs. G. L. Reisender
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28th, 1947 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 1947 to Jan 28 1947 and that I last saw h~~im~~ alive on Jan 28 1947

Immediate cause of death	DURATION
Cerebral apoplexy	5 days
Due to Arterio-Sclerotic Cardio vascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Baumgardner
M. D. or other

Address Balto 6 Date signed 1-29-47

Dr Baumgartner

1-35

8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

992 ★ RE 00286

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years, 1 month, 27 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 7 years, 1 month, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 230 South Castle Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Naughton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 18, 1860

8. AGE: Years	Months	Days	If less than one day
86	-	19	hrs. min.

9. Birthplace: ?
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Patrick Durkin
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof JAN- 9- 1947 (month) (day) (year)

Cemetery or crematory: NEW CATHEDRAL

Location: G.P. FREDERICK ROAD

18. Funeral director: Chas. S. Cramer Son Inc.

Address: 118 W. Mt. Royal Ave

19. 1/8 1947 H.W. Hedrick D.M.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 19 47 at 11:18p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10 19 39 to January 6 19 47 and that I last saw h... or alive on January 6 19 47

	DURATION
Immediate cause of death: Chronic myocarditis	indefinite
Due to: Chronic arteriosclerotic cardiovascular disease	"
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed: 1-7-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00287

CERTIFICATE OF DEATH

Reg. Dist. No. 34

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Sparks (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sparks
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stringtown Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Frances Laura Naylor

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife: John George Naylor

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): July 10, 1883

8. AGE: Years	Months	Days	If less than one day
63	6	16	...hrs. ...min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William Bull
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden name: Mary Thompson
15. Birthplace: Balto. Co. Md.

16. Informant: John G. Naylor
Address: Sparks, Md.

17. Burial, cremation, or removal. Which?: Burial Date thereof: Jan 28, 1947
(month) (day) (year)

Cemetery or crematory: Mt. Zion

Location: Upperco, Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. Date rec'd by registrar: Jan 29 1947

Cyril E. Fowble M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26 1947, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-26-'47 19..., to 1-26-'47 19...

and that I last saw her alive on not seen alive 19...

Immediate cause of death	DURATION
Angina Pectoris	1 wk.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? NONE (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dr D. D. Caples Med. Examiner
M. D. or other

Address: Reisterstown, Md. Date signed: 1-26-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246

00288

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A A

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 37 Cornhill Street
(If rural, give LOCATION)

2.(a) If veteran, name war WW-2

3. (a) FULL NAME GEORGE E. NORFOLK

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-14-1908

8. AGE: Years	Months	Days	If less than one day
38	7	4	..... hrs. ..... min.

9. Birthplace Prince George County, Md.
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER
12. Name Edward Norfolk
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden name Addie Brady
15. Birthplace Calvert Co., Md.

16. Informant Clinical Records, Vets. Adm. Hosp.,
Address Fort Howard, Maryland

17. Burial Date thereof Jan 21 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Friendship M. E.

Location Friendship, Maryland

18. Funeral director W. L. Hopkins

Address Annapolis, Md.

19. Jan. 20 1947 P. H. Farber
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 1947, at 5:15 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12, 1947, to January 18, 1947 and that I last saw him alive on January 18, 1947

Immediate cause of death	DURATION
HEMORRHAGE FROM THE ESOPHAGEAL VARICES	Unknown
Due to Cirrhosis of the liver	"
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation .....Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison M. D. or other

Address V.A. FT. HOWARD, MD. Date signed 1-18-47

R. M. CULLISON, M.D. CLIN. DIR.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

Evidence for change of year of birth is shown on Film B109-3/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(932) (11289)

Reg. Dist. No. 4 4 1

1. PLACE OF DEATH:

County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

309 Georgia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 309 Georgia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Betty Ohms.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Henry Ohms.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 26th. - 1865-4

8. AGE: Years 82 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation at Home.

11. Industry or business —

FATHER 12. Name August Schlenter

FATHER 13. Birthplace Germany.

MOTHER 14. Maiden name —

MOTHER 15. Birthplace —

16. Informant Conrad Ohms.

Address 309 Georgia Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/1/47 (month) (day) (year)

Cemetery or crematory Western

Location Edmondson Ave.

18. Funeral director John P. Connelly

Address 418 Eastern Ave. Essex 21, Md.

19. 1/30 1947 (Date rec'd by registrar) John P. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1947 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1947, to Jan 29 1947 and that I last saw h. alive on Jan 29 1947

Immediate cause of death	DURATION
Cerebral apoplexy	Sudden
Due to Arterio-Selerotic Cardio vascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. M. Baumgardner M. D. or other

Address Balto 6 Date signed 1-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

2-25

2-440 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00290

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 yrs.
Hospital, Institution, or street address where death occurred: 40 Bloomsbury Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No.: 40 Bloomsbury Ave (If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Shepherd Owens

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elvina Davidson Owens
6.(c) If alive, give age: 66 years
7. Birth date of deceased (mo., day, yr.): June 25, 1875

8. AGE: Years	Months	Days	If less than one day
72	—	5	hrs. min.

9. Birthplace: Baltimore Balto. Co. Md. (Town, county, and state)
10. Usual occupation: Letter carrier
11. Industry or business: Retired

FATHER
12. Name: Joseph Owens
13. Birthplace: Maryland

MOTHER
14. Maiden name: Eva Shepherd
15. Birthplace: Hancock, Md.

16. Informant: Mrs. Elvina Owens
Address: 40 Bloomsbury Ave Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 1 1947 (month) (day) (year)
Cemetery or crematory: Christ Church Yard
Location: Catonsville, Md.
18. Funeral director: Easton Sons
Address: 108 Frederick Ave Catonsville

19. 1-31 1947 (Date rec'd by registrar) Harry H. Muller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 30, 1947, at 11:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to June 30 1947 and that I last saw him alive on Jan 30 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: Cerebral Arterio Sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Alice Stowell M. D. or other
Address: Catonsville Date signed: 1-31

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

Evidence for the change of date of birth is shown on G 108 1/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d ★ 00291

Reg. Dist. No. 370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Baltimore
City or town Sparks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Sparks
(If outside city or town limits, write RURAL and give nearest town)
Street No. Belfast Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph Howard Parks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	married

6.(b) Name of husband or wife Emily C. Parks
6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1872

8. AGE: Years	Months	Days	If less than one day
75	11	1	hrs. min.

9. Birthplace Leias, Balto Co. Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name John R. Parks
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden name Sarah Brown
15. Birthplace Montgomery Co. Md.

16. Informant Mrs. Emily C. Parks
Address Sparks, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 22 47 (month) (day) (year)
Cemetery or crematory Jessops
Location Sparks, Md
19. Funeral director Landon M. Brooks
Address Sparks, Md

19. 1-20 1947 (Date rec'd by registrar) William C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1947 at 7A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion, with	1/20/47
Chronic myocarditis	Unknown
Due to Arteriosclerosis	
Hypertension	
Due to	
Other conditions Coronary Thrombosis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did Injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Rollin C. Hudson M.D. M.E.
M. D. or other
Address Towson Md Date signed 1/20/47.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00292

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville Texas Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville R.F.D. (If outside city or town limits, write RURAL and give nearest town)

Street No.: York Rd. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Gittings Parks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna V. Parks

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Jan 3, 1870

8. AGE: Years	Months	Days	If less than one day
77		21	hrs. min.

9. Birthplace: Texas Balto Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Wm Parks

13. Birthplace: Md.

MOTHER 14. Maiden name: Charcilla Shipley

15. Birthplace: Md.

16. Informant: Mrs Wm Parks

Address: Cockeysville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 27 47 (month) (day) (year)

Cemetery or crematory: Jessops Cemetery

Location: No Sparks Md.

18. Funeral director: [redacted] Brooks

Address: Sparks, Md

19. 1-24 19 47 (Data rec'd by registrar) Wilmer C. Enson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 24 1947 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	1/24/47
Due to Chronic Heart disease, myocarditis	5 yrs
Due to Hypertension Arteriosclerosis	Unk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Rollin G. Hudson M.D. D.M.E. M. D. or other

Address: Towson Md Date signed 1/24/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00293 33

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County: Balto.
City or town: Stevenson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Stevenson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: WILLIAM T. PARSLEY

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Emma J. Parsley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 24, 1874

8. AGE: Years	Months	Days	If less than one day
72	7	4	..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: Gardner
11. Industry or business

FATHER
12. Name: Thomas Parsley
13. Birthplace: Md.

MOTHER
14. Maiden name: Laura Grimes
15. Birthplace: Md,

16. Informant: Mrs. Emma S. Parsley
Address: Stevenson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31, 1947 (month) (day) (year)
Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 1/29/47 (Date rec'd by registrar) D. W. Herbert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28, 19 47 at 12:15p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to 1-29-47 19 ..... and that I last saw h... alive on 1-28-47 19 .....

Immediate cause of death	DURATION
Cerebral hemorrhage	1 day
Due to:	
Hypertension	years
Due to:	
Other conditions: Arteriosclerosis	Years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Reisterstown Md Date signed 1-29-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93C

00294 80

Reg. Dist. No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years, 8 months, 18 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 7 years, 8 months, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3540 Clipper Road

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Marion Pearce

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Carrie Fisher

6.(c) If alive, give age: 57 ? years

7. Birth date of deceased (mo., day, yr.): October 2, 1880

8. AGE: Years	Months	Days	If less than one day
66	3	17	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Cotton mill

FATHER 12. Name: Charles Pearce

FATHER 13. Birthplace: ?

MOTHER 14. Maiden name: Elizabeth Waters

MOTHER 15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 22 1947 (month) (day) (year)

Cemetery or crematory: Maryland Memorial Park

Location: Taylor Ave.

18. Funeral director: E. Kenworthy + Sons

Address: 2615-17 Eastern Ave.

19. 1/21/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1947 at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1939, to January 19 1947 and that I last saw h... im... alive on January 19 1947

Immediate cause of death	DURATION
Chronic myocarditis	indef.
Due to: Rheumatic heart disease	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville -28, Maryland Date signed: 1-20-47

Evidence for the addition of change of age is shown on G 108 2/3 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

00297

8

CERTIFICATE OF DEATH

Reg. Dist. No. 3 d

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 3 months, 7 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 3 years, 3 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1766 Homestead Street

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Mary V. Peat

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 2, 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69 70	10	7		

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Home

FATHER

12. Name: William Peat

13. Birthplace: Scotland

MOTHER

14. Maiden name: Mary Nelson Peterson

15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/11/47 (month) (day) (year)

Cemetery or crematory: Green Mount

Location: Balto. Md.

18. Funeral director: William Cook Inc.

Address: 1217 E. Pauls St.

19. 1/10 (Date rec'd by registrar) 19 47 A. C. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9 1947, at 9:00 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 2 1943 to January 9 1947 and that I last saw her alive on January 9 1947

	DURATION
Immediate cause of death: Chronic myocarditis	indef.
Due to: Chronic interstitial nephritis	"
Due to: Cystitis and pyelitis with hydronephrosis	"
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed 1-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00295 B

92b

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 606 N. Fremont Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: NATHANIEL PHEARS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Theol Phears

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): 12-29-97

8. AGE: Years	Months	Days	If less than one day
49	0	15	hrs. min.

9. Birthplace: Texas
(Town, county, and state)

10. Usual occupation: Barber

11. Industry or business:

FATHER
12. Name: Joseph Phears
13. Birthplace: Texas

MOTHER
14. Maiden name: Unknown
15. Birthplace: Texas

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-17-47 (month) (day) (year)

Cemetery or crematory: Bur. Veterans Cem.

Location: Fredrick Ave. Balto.

18. Funeral director: Charles L. Law

Address: 802 Mad. Ave.

19. Jan 16 1947 A. W. Hedrick 28 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 14, 1947, at 4:10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 13, 1947, to January 14, 1947 and that I last saw him alive on January 14, 1947

Immediate cause of death	DURATION
Mitral Insufficiency	20 Yrs.
Due to: Rheumatic Fever	" "
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison M. D. or other
R.M. CULLISON, M.D. CLIN. DIR.

Address: V.A. FT. HOWARD, MD. Date signed: 1-15-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 la

00296

Reg. Dist. No. 440

PLEASE TYPE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, Maryland

How long in hospital or institution? 43 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Worton

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route #110 Box #2

(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3.(a) FULL NAME ROMIE PHILLIPS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Helen Phillips

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 4-8-1892

8. AGE: Years	Months	Days	If less than one day
54	9	19	..... hrs. ..... min.

9. Birthplace Worton, Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Norah Phillips

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Clara Bowers

MOTHER 15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. BURIAL (Burial, cremation, or removal—which?) Date thereof 1-29-47 (month) (day) (year)

Cemetery or crematory

Location STILL POND, MARYLAND

18. Funeral director Charles R. LAW

Address 802 Madison Ave

19. Jan 27 1947 (Date rec'd by registrar) Dawson L. Hooper Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1947 at 6:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15, 1946, to January 27, 1947 and that I last saw him alive on January 27, 1947

Immediate cause of death	DURATION
Pulmonary infarction, rt. lower lobe, cause unknown	12 Days
Due to	
Due to	
Other conditions Hypertensive Heart disease	10 Yrs.
Nephrosclerosis and Duodenal Ulcer	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison

R. M. CULLISON, M.D. CLIN. DIR. Other

Address V.A. Ft. Howard, Md. Date signed 1-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00298

181a

CERTIFICATE OF DEATH

Reg. Diat. No. 43

1. PLACE OF DEATH:

County Balto.

City or town Pasadena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

4 Elinor Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto Co.

City or town Pasadena Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4 Elinor Ave

(If rural, give LOCATION)

2.(a) If veteran, name war NO

3. (a) FULL NAME John F. Poole

3. (b) Social Security Number 217-09-1104

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ethel Margaret Poole

June 18 1844 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 20-1887

8. AGE: Years	Months	Days	If less than one day
59	10	14	..... hrs. ..... min.

9. Birthplace Norrmouse Co Va

(Town, county, and state)

10. Usual occupation Measurer.

11. Industry or business Saw Mills

FATHER 12. Name Wm Robert Poole

13. Birthplace Va.

MOTHER 14. Maiden name Mary E. Maybaew

15. Birthplace Va

16. Informant Ethel M. Poole wife

Address 4 Elenor Av

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 6 47 (month) (day) (year)

Cemetery or crematory Parkwood

Location Balto Md.

18. Funeral director Lansdale Funeral Home

Address 7401 Belair Rd.

19. 1-3- 1947 Mrs. O. L. Reifsnider Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3rd 1947, at 2 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1946, to Jan 3 1947

and that I last saw h... alive on Jan 2 1947

Immediate cause of death	DURATION
Coronary Occlusion	3 days
Due to Arteria Sclerosis Hypertension	4 yrs
Arteria Sclera Coronary Artery	+ yrs
Due to Chr. Interstitial Nephritis	+ yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T F A Stevens M. D. or other

Address 2816 Harford Rd Date signed 1-3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00299

Reg. Dist. No. 30

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 18 Wyndcrest Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 18 Wyndcrest Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Herman Postelman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Goebel Postelman

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1872

8. AGE: Years	Months	Days	If less than one day
74	3	19	...hrs. ...min.

9. Birthplace: Koenigsberg Preisen, Germany (Town, county, and state)

10. Usual occupation: Farmer - retired

11. Industry or business: Own farm

FATHER 12. Name: Carl Edward Postelman

FATHER 13. Birthplace: Preisen, Germany

MOTHER 14. Maiden name: Caroline Schreiber

MOTHER 15. Birthplace: Germany

16. Informant: Elizabeth Postelman

Address: 18 Wyndcrest Ave. Catons.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 9, 1947 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Frederick Ave. Balto. Md.

18. Funeral director: Eastern Sons

Address: 603 Frederick Ave. Catons. Md.

19. Jan 8 1947 (Date rec'd by registrar) Harry D. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 6th 1947, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1944, to 1/6 1947

and that I last saw h. 1/4 alive on 1/4 1947

Immediate cause of death	DURATION
Acute Intestinal Obstruction	5 Days
Due to: Carcinoma Stomach	3 Yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Inoperable Carcinoma Stomach Date of op. Dec 1947

Autopsy results: Not Done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edward F. Healy M.D. (M. D. or other)

Address: 301 Med. Arts. Date signed: 1/7/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 00360 8

Reg. Dist. No. 381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 812 Eighth Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 7807 York Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Margaret R Price

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Fulton C Price

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 14, 1877

8. AGE: Years: 69 | Months: 2 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state) Md

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Edward Cutler

13. Birthplace: Hagerstown Md

MOTHER 14. Maiden name: Amanda Frederick

15. Birthplace: Baltimore Md

16. Informant: Fulton C Price

Address: 7807 York Rd Towson

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/25/47 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Catonsville Md

18. Funeral director: Fulton Col Sons

Address: 1217 E Fayette

18. 1/24 (Date rec'd by registrar) 19 47 Geo Hadrick Registrar

DR

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 22 19 47 at 10 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 19 45 to Jan 22 19 47

and that I last saw h[illegible] alive on Jan 22 19 47

Immediate cause of death	DURATION
Asphyxia	12 hrs.
Due to Uremia & Nephritis	
Due to Hypertension	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas Cullen M.D. M. D. or other

Address: Towson Md Date signed: 1/23/47

00301 R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 3 mos., 10 days
Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
How long in hospital or institution? 1 yr., 3 mos., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 715 S. Bond Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War

3.(a) FULL NAME: HARRY M. RATHELL

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Divorced
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 14, 1892

8. AGE:	Years	Months	Days	If less than one day
	54	10	16	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: John A. Rathell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sara Claypoole
15. Birthplace: Maryland

16. Informant: Clinical Records, Veterans Administration Hospital, Ft. Howard, Md.
Address

17. Burial (Burial, cremation, or removal? Which?) Date thereof: February 2-47 (month) (day) (year)
Cemetery or crematory: Loudon Park. Cem.
Location: Frederick Road.

18. Funeral director: John A. Miller
Address: 2334 Jefferson St. Balto. Md.

19. 2/Feb 19 47 A.W. Lodrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 19 47 at 11:56 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 20 19 45, to January 30 19 47 and that I last saw him alive on January 30 19 47

	DURATION
Immediate cause of death: FAILURE OF LEFT VENTRICLE	3 days
Due to: Rheumatic Endocarditis	10 yrs.
Due to:	
Other conditions: Dilatation and hypertrophy associated with insufficiency of aortic valve (Include pregnancy within 3 months of death)	~~10 yrs.~~ weeks

Major findings of operations: ..... Date of op. .....
Autopsy results: Substantiated Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison
R.M. CULLISON, M. D. Clinical Dir.
M. D. or other
Address: V.A.H. Fort Howard, Md. Date signed: 1-30-47

Rec'd VS
2/1/47

STATE OF MARYLAND—CERTIFICATE OF DEATH 0302

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

1. PLACE OF DEATH

County Balto. Registration Dist. No. 44

Village or City Middle River No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Joan Marie Reier.

(a) Residence: No. By 169 RD 16. St. Hilloside Ave. Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Fem.	White	Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) Apr 21 1946

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	7	

OCCUPATION

8. Trede, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Nurse

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. None

10. Oate deceesed last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State er country) Harford Co. Md.

FATHER

13. NAME James Martin Reier.

14. BIRTHPLACE (city or town) (State or country) New York

MOTHER

15. MAIDEN NAME Margaret Ann Bradley

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT James M. Reier. (Address) above

18. BURIAL, CREMATION, OR REMOVAL Place Hyde Pk Burial Date Jan 31, 1947

19. UNDERTAKER James Boulmore (Address) 140 Park Ave Rd

20. FILED Jan 29, 1947 A. W. Hedrick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan 28, 1947 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1947, to Jan 28, 1947

I last saw her alive on Dead, 19; death is said to have occurred on the date stated above, at m.

The **PRINCIPAL CAUSE OF DEATH** end related causes of importance were as follows:

	Oate of onset
Acute Infantile Enteritis.	

Other **Contributory Causes** of importance:

Name of operetion Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Oate of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. M. Carmine M. D. M. O.

(Address) Deputy Medical Examiner Randallstown, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home.** For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The **principal cause of death** and related causes of importance were as follows:	Date of onset	The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other **contributory causes** of importance:		Other **contributory causes** of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 * 00303 18C

Reg. Dist. No. 351

8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 812 Register Ave. (Armacost Nurs. Home)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No.: 3102 Batavia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MARY E. REIER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Adam Reier
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1861

8. AGE: Years	Months	Days	If less than one day
85	3	4	hrs. min.

8. Birthplace: Harford Co., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: George Stiegler
13. Birthplace: Germany

MOTHER
14. Maiden name: Elnora Fischer
15. Birthplace: Germany

16. Informant: Mr. Harold S. Reier
Address: 3102 Batavia Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/3/47 (month) (day) (year)
Cemetery or crematory: Parkwood Cem.
Location: Balto., Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. Jan 3 19 47 (Date rec'd by registrar) C. W. Holland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 1, 19 47 at 1:57 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1st 1943 to Jan 1st 1947 and that I last saw her alive on Dec 30th 1946

Immediate cause of death	DURATION
Chronic myocarditis	2 years
Due to	
Due to	
Other conditions Cerebral Hemorrhage.	Aug 1943
Cerebral Hemorrhage (Include pregnancy within 3 months of death)	Aug 15 1946

Major findings of operations: none Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of
Where did injury occur? none (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. L. Gordy M.D. M. D. or other
Address: 5106 Harford Rd Date signed 1-2-47

00304 f

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

130

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 702 Bradley Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME: JAMES A RICH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Evelyn Rich

6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): 4/10/1916

8. AGE: Years	Months	Days	If less than one day
30	9	5	....hrs. ....min.

9. Birthplace: Richmond Co., Virginia (Town, county, and state)

10. Usual occupation: Welder

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Sufronia Blue

15. Birthplace: Unknown

16. Informant: Clinical Records, Vets.Adm.Hosp.

Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-20-47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cem.

Location: Baltimore, Md.

18. Funeral director: Mrs. Frances A. Hemsley

Address: 578 W. Biddle St.

19. Jan 17 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 19 47 at 7:35 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 3 19 47, to January 15 19 47 and that I last saw h. i.m. alive on January 15 19 47

Immediate cause of death	DURATION
Subacute glomerular Nephritis	2 Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of ....

Where did injury occur? ....(City or town) ....(County) ....(State)

Injured at home, farm, industry, public place (where?) ....

Means of injury: ....Injured at work?

23. SIGNATURE: Robert M. Cullison M.D. or other

R.M. CULLISON, M.D. CLIN. DIR.

Address: V.A., Ft. Howard, Md. Date signed 1-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 00305 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years, 2 months, 8 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 13 years, 2 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1026 E. 20th St.

(If rural, give LOCATION)

2.(a) If veteran, name war: –

3. (a) FULL NAME: Bessie M. Richardson

3. (b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	divorced

6.(b) Name of husband or wife: Harry C. Richardson

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): November 18, 1888

8. AGE: Years	Months	Days	If less than one day
58	1	23	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER 12. Name: John P. Busch

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Airey E. Bramble

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Catonsville 28, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 1/13/47 (month) (day) (year)

Cemetery or ~~crematory~~: Loudon Park

Location: Balto. Md.

18. Funeral director: William Cook Inc

Address: 1217 St. Paul St.

19. 1-13 47 (Date rec'd by registrar) A.W. Hahn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 19 47 at 6:46 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2 19 33, to January 10 19 47 and that I last saw h...er alive on January 10 19 47

Immediate cause of death	DURATION
General paresis	Indef.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results: none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D. M. D. or other

Address: Catonsville 28, Md. Date signed: 1/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00306

CERTIFICATE OF DEATH

#64

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore.
City or town Catonsville.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 weeks.
Hospital, Institution or street address where death occurred:
Opitz Home - Edmondson Ave & Nunney Lane.
How long in hospital or institution? 6 wks. — Lane.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Opitz Home - Edmondson Ave & —
(If rural, give LOCATION)
2.(a) If veteran, name war None. — Nunney Lane.

3.(a) FULL NAME Elizabeth Riley -

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed.
6.(b) Name of husband or wife: Eben Riley.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): January 28 1871.

8. AGE: Years 75 Months 11 Days 27 If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business At home.
FATHER 12. Name Herman Ulcher.
13. Birthplace Germany.
MOTHER 14. Maiden name ? Inglehart
15. Birthplace Germany.
16. Informant Mr. Herbert Riley.
Address 2538 Hollins St.
17. Burial. Date thereof Jan. 27 - 47. (Burial, cremation, or removal: Which) (month) (day) (year)
Cemetery or crematory Western Cemetery.
Location Baltimore Md.
18. Funeral director Charles J. Schwab.
Address 3512 Frederick Ave.
19. 1/27 1947 F. W. Kedrick D.C. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 — 1947 at 2.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 47, to Jan 24 1947 and that I last saw her alive on Jan 24 1947

	DURATION
Immediate cause of death Pulmonary edema	24 hrs
Due to Coronary Occlusion	
Due to Arteriosclerotic CV Disease	
Other conditions Carcinoma, rectum	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Herman H. Bayless M. D. or other
Address 1600 Wilkens Ave Date signed 25 Jan 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

CERTIFICATE OF DEATH

Reg. Dist. No. 00303 01

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 years, 10 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 1 year, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 807 South Luzerne Avenue (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Michael Rochowiak

3. (b) Social Security Number

4. Sex male

5. Color or race white

6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Frances ?

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) September 1864

8. AGE: Years 82 Months 4 Days ? If less than one day ... hrs. ... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Laboring

11. Industry or business Unknown

FATHER 12. Name ? Rochowiak

13. Birthplace Germany

MOTHER 14. Maiden name ?

15. Birthplace Germany

16. Informant Hospital records

Address Catonsville-28, Md.

17. Burial Date thereof 1-16-47 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory St Stanislaus

Location Baltimore Md.

18. Funeral director George A Weber

Address 705 S. Ann st

19. 1-15 19 47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 19 47 at 4:45a.m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to Cardio vascular disease	
Due to fracture of left femur	
Other conditions accident	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of about Jan 11. 47

Where did injury occur? Catonsville (City or town) Balto (County) md (State)

Injured at home, farm, industry, public place (where?) hospital

Means of injury fall on floor Injured at work? no

23. SIGNATURE Geo. S. McKieffer Dep. Med. Exam of Balto Co M. D. or other

Address 1010 Leeds ave Date signed Jan 13, 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

00307

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mc Henry Road
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Fannie Gibbons Rogers

3.(b) Social Security Number: —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: C. Lyon Rogers
Deceased
6.(c) If alive, give age: ... years
7. Birth date of deceased (mo., day, yr.): March 5 - 1860
8. AGE: Years: 76 Months: 10 Days: 22 If less than one day: ... hrs. ... min.
9. Birthplace: Baltimore Co. Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Rodmond Gibbons
13. Birthplace: Wilmington, Delaware

MOTHER
14. Maiden name: Fannie Lyon
15. Birthplace: Balto Co. Md

16. Informant: Rebecca Davidson Gibbons
Address: Sudbrook Lane, Pikesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 29, 47 (month) (day) (year)
Cemetery or crematory: St. Thomas
Location: Garrison Forest
18. Funeral director: Frank S. Newell
Address: Pikesville, Maryland
19. 1 - 28 - 1947 (Date rec'd by registrar) Dr. E. E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 1947 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1931 to Jan 27 1947 and that I last saw h[illegible] alive on Jan 25 1947

Immediate cause of death	DURATION
arterio - sclerosis	15 yrs.
Due to: Diabetes Mellitus	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Palmer R Wilson M. D. or other
Address: Pikesville 8 Date signed: Jan 27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00309 8

CERTIFICATE OF DEATH

932 ★

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Baltimore

City or town Halethorpe

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Weeks

~~Hospital, institution, or street address where death occurred:~~

5642 Garville ave

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Ba

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 119 N. Linwood ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rose Rosasco

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widow

6.(b) Name of husband or wife late Louis N Rosasco

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 20-1867

8. AGE: Years	Months	Days	If less than one day
79	6	1	...hrs. ...min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER — 12. Name Benedict Malasto

13. Birthplace Italy

MOTHER — 14. Maiden name Olivia Aratta

15. Birthplace Italy

16. Informant Mrs Milan

Address 5642 Garville ave Halethorpe

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 25-1947 (month) (day) (year)

Cemetery or crematory New Cathedral

Location Baltimore Md

18. Funeral director Frank T Pipitone

Address 2818 E Balto St

19. 1/24 1947 A. W. Hebert (Date rec'd by Registrar) (By) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1947, at 12:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 1946, to January 24 1947

and that I last saw her alive on January 22 1947

Immediate cause of death	DURATION
Arteriosclerotic Cardio-vascular disease	1 year
Due to	
Due to	
Other conditions Central thrombosis	1 day

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert H Katz M. D. or other

Address 2030 Walker Ave Date signed Jan 27 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00310 P

120 P

Reg. Dist. No. 440

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 19 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Hanover

(If outside city or town limits, write RURAL and give nearest town)

Street No. Hanover, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: ALBERT L. ROSS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Dorothy Ross

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): 1-13-1899

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
47	11	18		

9. Birthplace: Dorsey, Maryland

(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business:

FATHER

12. Name: Alfred Ross

13. Birthplace: Virginia

MOTHER

14. Maiden name: Jessie R. Litchfield

15. Birthplace: Baltimore, Md.

16. Informant: Registrar's Office, Clin. Records

Address: Vets. Adm. Hosp., Ft. Howard, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 1/4/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cem.

Location: 5501 Frederick Ave

18. Funeral director: John J. Bowane & Son

Address: 901-03 E. Collins St.

19. 1-3 19 47 (Date rec'd by registrar) Registrar

1-25

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1, 1947 at 8:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 13, 1946, to January 1, 1947 and that I last saw him alive on January 1, 1947

Immediate cause of death	DURATION
Acute ulcerative colitis with	1 Year
rupture and peritonitis	12 Hrs.
Due to	
Due to	
Other conditions: Polyposis of colon and duodenum	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison

R. M. CULLISON, M.D. CLIN. DIR. M.D. or other

Address: V.A. FT. HOWARD, MD. Date signed 1-2-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50 00311

4

CERTIFICATE OF DEATH

Reg. Diat. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 64 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 27 Wade avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MARGARET M. SCANNELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: John C. Scannell

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 30, 1865

8. AGE: Years	Months	Days	If less than one day
81	6	25	..... hrs. ..... min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Michael Lucey

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Johanna O'Shea

15. Birthplace: Ireland

16. Informant: Miss Margaret Scannell

Address: 27 Wade ave. Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 28, 1947 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Old Frederick road, Balto. Md.

18. Funeral director: Chas. P. Evans Son, Inc.

Address: 118 N. Mt. Royal Ave.

19. 1/27 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 25 19 47 at 1:20 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from [illegible] 19 46 to 1-25 19 47

and that I last saw h[illegible] alive on 1-25 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to Cardio Vascular Renal Dis	2 yrs. ?
Due to Carcinoma Breast	6 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Catonsville, Md. Date signed 1-27-47

DR. GEORGE E. URBAN
803 FREDERICK ROAD
PES - 23 SEMINOLE RD
CAT - 310

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13a 00312

Reg. Dist. No. 321

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Balto Co

City or town Catonsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto

City or town Catonsville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 302 Harlem Lane

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Schaub

3. (b) Social Security Number

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Eliz.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 10, 1882

8. AGE: Years 64 | Months 6 | Days 2 | If less than one day ____ hrs. ____ min.

9. Birthplace Catonsville Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Geo Schaub

13. Birthplace Md

MOTHER 14. Maiden name Catherine Peters

15. Birthplace Md

16. Informant Mrs Blanche Yates

Address Ellicott City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-30-47 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Baltimore Maryland

18. Funeral director E C Hegenbottom

Address Ellicott City Md.

19. 1-29 (Date rec'd by registrar) 1947 Harry W Mueller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1947, at 19 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21 1939, to January 27 1947, and that I last saw him alive on January 26 1947.

	DURATION
Immediate cause of death: Myocardial Degeneration	3 mo.
Due to Chronic Cardio-Vascular-Renal Disease	8 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wilmer K. Gallagher M.D. M. D. or other

Address Catonsville-28, Md. Date signed 1/27/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00313

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County Balto Co
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State Md County Balto.
City or town Glenarm (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Howard Milton Schneider
3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23 - 1946

8. AGE: Years — Months — Days 17 If less than one day hrs. min.

9. Birthplace Balto Co Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Joseph M. Schneider
13. Birthplace Md.

MOTHER
14. Maiden name Lola M. Reed
15. Birthplace Md.

16. Informant Joseph M. Schneider
Address Glenarm Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 11-47 (month) (day) (year)
Cemetery or crematory Union Chapel
Location Joppa Harford Co Md

18. Funeral director Clarence V. Arthur
Address Joh Balto Md.

19 Jan 10 19 47 (Date rec'd by registrar) C. E. Arthur Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 19 47 at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 19 47 to Jan. 9, 19 47 and that I last saw h alive on Jan 9 19 47

	DURATION
Immediate cause of death Cerebral hemorrhage	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford T. Tudson, MD M. D. or other
Address York MD Date signed 1/9/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-25

00314

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157 a

CERTIFICATE OF DEATH

Reg. Dist. No. BC 320

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5years, 11months, 18days
Hospital, institution, or street address where death occurred:
Rosewood School
How long in hospital or institution? 5 yrs. 11 Mos. 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 2202 West Wood Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Martin Philip Seidman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) October 8, 1935

8. AGE: Years	Months	Days	If less than one day
11	3	20	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: None - inmate
11. Industry or business

MOTHER FATHER
12. Name: David Seidman
13. Birthplace: Russia
MOTHER
14. Maiden name: Cohn (Anna)
15. Birthplace: Russia

16. Informant: Rosewood State School Records
Address: Owings Mills, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 30-47 (month) (day) (year)
Cemetery or crematory: Bnai Israel Cemetery
Location: 3701 Southern Ave
18. Funeral director: Sol Levinson & Bros
Address: 1126 W. North Ave. Balto 17

19. 1-29-1947 (Date rec'd by registrar) Dr. E. E. Nichols Co. Med Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28, 1947 at 5.10p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10 1941 to Jan. 28 1947 and that I last saw him alive on January 28 1947

Immediate cause of death	DURATION
Broncho pneumonia -	1 day
Due to La Grippe	2 days
Due to	
Other conditions Congenital heart disease & generalized deep cyanosis 5 yrs. 11 months plus. Mongoloid - Life	

(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE: Isabel H. W. Clinton M.D. M. D. or other
Address: Rosewood - Owings Mills Md. Date signed: Jan. 29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00315 P

1866

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Balto.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Hood Nursing Home - 5501 Edmondson Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5207 Cuthbert Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SARAH ELIZABETH HIGGINS SENNETT

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Howard Sennett

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 6, 1870

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
76	9	11		

9. Birthplace: Chesterstown, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: William A. Linder

13. Birthplace: Germany

MOTHER — 14. Maiden name: Frances Murphy

15. Birthplace: Md.

16. Informant: Mrs. J. Irving Disney, daughter

Address: 5207 Cuthbert Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/20/47 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem.

Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 1/18 19 47 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17, 19 47 at 6:15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 19 47 to Jan 17 19 47 and that I last saw h- ex alive on Jan 17 19 47

Immediate cause of death	DURATION
Arterio Sclerotic Cardio Vascular Disease	10 days
Due to: Arterio Sclerosis	
Due to:	

Other conditions: ① Hypostatic Congestion of Lungs - 5 days ② Fracture of R. Hip. Dec 18-46

(Include pregnancy within 3 months of death)

Major findings of operations: Fracture of R Hip — Roger Anderson Splint Date of op. 12-21-46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 12-18-46

Where did injury occur? Belvedere Ave Balto Md. (City or town) (County) (State)

Injured at home, farm, industry, public place, (where?) Food Fair Store

Means of injury: Pushed over by door Injured at work? no

23. SIGNATURE: James Stowell M. D. or other

Address: Calvert Bldg Date signed 1-17-47

Howard S. Maldeis, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00316

CERTIFICATE OF DEATH

Reg. Dist. No. 34

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural - Mt Carmel - Upperco P.O.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rural - Mt. Carmel Upperco P.O.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mt - Carmel Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Marie Shoek

3.(b) Social Security Number: 212-26-5213

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	married

6.(b) Name of husband or wife: Arthur J. Shoek

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): May 29, 1920

8. AGE: Years	Months	Days	If less than one day
26	7	19	...hrs. ...min.

8. Birthplace: Balto. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife - 2 yrs.

11. Industry or business: Machine Operator prior to marriage

FATHER
12. Name: William A. Fowble
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Grace A. Cole
15. Birthplace: Balto. Co., Md.

16. Informant: W... A. Fowble
Address: Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 19, 1947 (month) (day) (year)

Cemetery or crematory: Bakers

Location: Falls Rd. - Lutherville, Md.

18. Funeral director: Landon M. Brooks

Address: Sparks, Md.

19. Jan 21 1947 (Date rec'd by registrar) Cyril E. Fourth M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 15 1947 at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Pleadon Eclampsia	
Carbon Monoxide Poisoning	
Due to: Accidental. Occurred in a house. S.W.S.O.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): at home

Means of injury: Injured at work?

23. SIGNATURE: G. M. France M. D. or other

Address: Parkton, Md. Date signed: 1/17/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00317

Reg. Diat. No. 340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: (Rural) Mt. Carmel - Upperco P. O.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: (Rural) Mt. Carmel - Upperco P. O.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mt. Carmel & Forest Rds.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME Arthur James Shock

3.(b) Social Security Number 217-12-0357

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	married

6.(b) Name of husband or wife: Anna Marie (nee Trouble)

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 13, 1914

8. AGE: Years	Months	Days	If less than one day
32	8	2	..... hrs. ..... min.

9. Birthplace: Balto. Co., Md.
(Town, county, and state)

10. Usual occupation: Screw Machine Operator

11. Industry or business: Black & Decker Mfg. Co.

FATHER 12. Name: Chas. E. Shock

13. Birthplace: Balto. Co. Md.

MOTHER 14. Maiden name: Helene Agnetta Brooks

15. Birthplace: Balto. Co. Md.

16. Informant: Chas. E. Shock

Address: Pondrom Rd, Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 19 1947 (month) (day) (year)

Cemetery or crematory: Sater's -

Location: Falls Rd. Southerville, Md.

18. Funeral director: Sandon M. Brooks

Address: Govl. Md.

19. Jan 21 1947 (Date rec'd by registrar) April E. Frantz M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 15 1947 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on Jan. 15 1947

Immediate cause of death	DURATION
Carcinoma Monocaste	
Peritonitis	
Due to: Accidental. Occurred in a house.	
Cause.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of .....

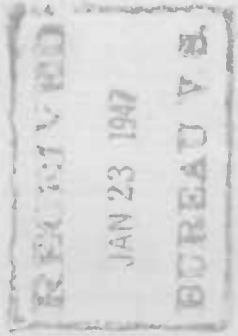
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): At home.

Means of injury ..... Injured at work?

23. SIGNATURE: A. M. Fremuth M. D. or other

Address: Parkton, Md. Date signed 1/17/47



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Balto

City or town: Dundalk md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, Institution, or street address where death occurred:
6813 Dunhill Road

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME: Julia Medley Sloneeker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: Adam B Sloneeker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 1 1862

8. AGE: Years	Months	Days	If less than one day
84	3	16	..... hrs. ..... min.

9. Birthplace: Greensburg Pa
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Jacob Brandtler
13. Birthplace: Pa

MOTHER
14. Maiden name: Margaret Wyant
15. Birthplace: Pa

16. Informant: Marian Sloneeker

Address: Elkton. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 20 1947 (month) (day) (year)

Cemetery or crematory: Elkton cemetery

Location: Elkton. Md

Undertaker or director: H. W. Pippin

Elkton. Md

18. Jan 18 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-17-47 19 47, at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 44, to 1-17-47 19 47

and that I last saw h... alive on 1-17-47 19 ...

Immediate cause of death	DURATION
Coronary Thrombosis	1d
Due to: Arteriosclerosis Generalized	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Eugene F Neary M.D.
M. D. or other

Address: 701 Bunker Hill Rd Elkton Md. Date signed: 1/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00318

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 33 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Balto.

City or town Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Patrick Henry Smith

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Catherine Shea Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
90	10	10	..... hrs. ..... min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name John Smith

13. Birthplace Ireland

MOTHER

14. Maiden name Winifred Egan

15. Birthplace Ireland

16. Informant Winifred Smith

Address Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30, 1947 (month) (day) (year)

Cemetery or crematory Druid Ridge

Location Balto. Co.

18. Funeral director J.F. Eline & Sons

Address Reisterstown, Md.

19. Jan - 29 - 1947 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1947, at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/5/40 1947, to 1/27/47 1947

and that I last saw h.. alive on 1/26/47 1947

Immediate cause of death	DURATION
myocarditis	
chronic decompensation	
Due to hypertension	
Due to arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. L. Talbott M. D. or other

Address Reisterstown Md Date signed 1/27/47

1-35

Evidence for change of year of birth shown on File 6109 3/20/47-B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131)

00319

CERTIFICATE OF DEATH

Reg. Diat. No. 6 (0

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 121 Dundalk Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Robert Louis Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widower

6.(b) Name of husband or wife: Elizabeth A. Smith

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 2, 1863

8. AGE: Years	Months	Days	If less than one day
84	1	27	hrs. min.

9. Birthplace: Baltimore County (Town, county, and state)

10. Usual occupation: Watchman

11. Industry or business: Garage

FATHER

12. Name: Unknown

13. Birthplace: "

MOTHER

14. Maiden name: "

15. Birthplace: "

16. Informant: Mrs. Elmer L. Miller

Address: 121 Dundalk Ave., Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 1, 1947 (month) (day) (year)

Cemetery or crematory: Zion Cemetery

Location: Golden Ring Road

18. Funeral director: Roland L. Fuhrer

Address: 2112 Dundalk Ave.

19. 1/31/47 (Date rec'd by registrar) 19.. H. McCormick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 29 19 47, at 8 40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 46, to Jan 29 19 47 and that I last saw h- alive on Jan 29 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Hypertension Cardio-Vascular Renal Disease	4 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. R. Evans M. D. or other

Address: 1 Liberty Parkway Date signed: 1-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00320

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Rosedale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Rosedale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1314 Rosemick Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sophia M Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Jos E Smith
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 17- 1885

8. AGE: Years	Months	Days	If less than one day
62			..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation:
11. Industry or business: At Home

FATHER
12. Name: Henry Roth
13. Birthplace: Balto

MOTHER
14. Maiden name: Dont Know
15. Birthplace: Balto

16. Informant: Jos E Smith
Address: 1314 Rosemick Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 18 (month) (day) (year)
Cemetery or crematory: Parkwood Cem
Location: Rural

18. Funeral director: Ulrich Funeral Home
Address: 2008 Orleans St

19. ..... 19..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14th 19 47, at 9 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 36 to Jan 10 19 47
and that I last saw h[illegible] alive on January 10 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	0
Due to: Hypertension Arterio-	2
Due to: Vascular Lesion.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emma G. Mayo M.D.
M. D. or other
Address: 716 Putnam Ave Date signed Jan 14 47

Ernest (our Bldg Supt. & janitor) sent Mr. Ulrich Sr. to the City Health Dept this a.m. (before my arrival at 8:55) for a Burial Permit - which they gave him. Ulrich, Jr. brought the cert. up from "Mac" at the City.

[redacted] — O.M.S.

11/18/47

STATE OF MARYLAND—CERTIFICATE OF DEATH

00321

1. PLACE OF DEATH

County Balto Registration Dist. No. 41-0

Village or City Dundalk ND. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME George H. Snowden

(a) Residence: No. Phells Farm Stage Rte. 7965 Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Colored	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Snowden

6. DATE OF BIRTH (month, day, and year) Mar 1 1881

7. AGE Yeers	Months	Deys	If LESS than 1 day, hrs. or min.
65	9	—	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Laborer

9. Industry or business in which work was done, as STAVE MILL, SAW MILL, BANK, etc. Farm.

10. Date deceased last worked at this occupation (month and year) 1946

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) A. A. Co. Md

FATHER

13. NAME Mr. Snowden

14. BIRTHPLACE (city or town) (State or country) A.A. Co Md.

MOTHER

15. MAIDEN NAME Eliza Watkins

16. BIRTHPLACE (city or town) (State or country) A. A. Co Md

17. INFORMANT Mamie Snowden (Address) Dundalk Md

18. BURIAL, CREMATION, OR REMOVAL Place Mt Carmel Sion Date Jan 6, 1947

19. UNDERTAKER Elroy O Wilson (Address) 1000 Broadway

20. FILED 1-6, 1947 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 1 (Dey), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1947 to Jan 1, 1947

I last saw h[illegible]elive on , 19 ; death is said to have occurred on the date stated ebova, at m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Coronary occlusion	Instant.

Dther **Contributory Causes** of importence:

Name of operetion Date of

Whet test confirmed diegnosis? Was there an autopsy?

23. If deeth wes due to externel ceuses (VIOLENCE) fill in also the following:

Accident, suicida, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Neture of injury

24. Wes disease or injury in any wey releted to occupetion of deceesed?

If so, specify

(Signed) J. McPherson M.D. M. D.

(Addrass) Deputy Medical Examiner

If more blanks are needed, address State Registrar, 311 N. Charles Street, Baltimore, Requesting U. S. No. 1.

Dundalk Md 1/1/47

1-35

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

48a

00322

Reg. Dist. No. 41

8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk 925 Short Road
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Dundalk, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 925 Short Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Viola Smith (Or) Viola Stachowski

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband: XXX William

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): February 14-1904

8. AGE: Years	Months	Days	If less than one day
42	11	14	...hrs. ...min.

9. Birthplace: Baltimore, Maryland.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

MOTHER FATHER

12. Name: Joseph Kane

13. Birthplace: Poland

14. Maiden name: Michalena Golembieski

15. Birthplace: Poland

16. Informant: William Smith

Address: 925 Short Rd-Dundalk, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-31-47 (month) (day) (year)

Cemetery or crematory: Sacred Heart Of Mary

Location: Baltimore County, Maryland.

18. Funeral director: George R Weber

Address: 705 South Ann Street

19. 1/29 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28th 1947, at 11 06 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1946, to Jan 28 1947 and that I last saw h... alive on Jan 28 1947

	DURATION
Immediate cause of death: Carcinoma of the Cervix	2 years
Due to:	
Due to:	
Other conditions: Tertiary Lues	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Eugene F Neag M. D. or other

Address: 7001 Mohington Ave, Dundalk, Md Date signed: Jan 29 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00323

61

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cert[ificate] is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Balto
City or town Sparrows Pt. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town ~~Balto~~ Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 527 Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alexander Stokes

3.(b) Social Security Number

4. Sex M
5. Color or race Bl
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Viola
6.(c) If alive, give age 46 years
7. Birth date of deceased (mo., day, yr.) Dec. 5, 1896
8. AGE: Years 50 Months Days If less than one day hrs. min.
9. Birthplace Va. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Bethlehem Steel Co
FATHER 12. Name James Stokes
13. Birthplace Va.
MOTHER 14. Maiden name Iola Crafton
15. Birthplace Va
16. Informant Viola Stokes
Address 527 Main St. Dundalk
17. Removal (Burial, cremation, or removal, Which?) Date thereof Jan 5 1947 (month) (day) (year)
Cemetery or crematory
Location Meherrin Va.
18. Funeral director Mrs. Robt. A. Elliott & Daughter
Address 1129 N. Caroline St.
19. 1/5 19 47 (Date rec'd by registrar) Milton W Mulson Local Registrar
Deputy W.M. Carmine Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1947 at 2:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death Coronary Occlusion	—
Due to —	
Due to —	
Other conditions Diabetes Mellitus (Include pregnancy within 3 months of death)	1 yr. —

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. B. Davis M.D. M.D. or other
Dept. Med. Examiner Balto. Co.
Address Dundalk Md Date signed 1/3/47

VS A15 9-45 15M

2-22

1-410-2-10

Evidence for the addition of age and year of birth was added as per phone conversation with Undertaker 2/6/47 PRC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00324

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Balto
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 704 Homberg Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 704 Homberg Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Henry Stratemeyer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife: Mollie
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 1878

8. AGE: Years: 69 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Balto (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Balto Copper Works
FATHER 12. Name: John Stratemeyer
13. Birthplace: Penn
MOTHER 14. Maiden name: Unde
15. Birthplace: "
16. Informant: John Henry Stratemeyer
Address: 704 Homberg Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-30-47 (month) (day) (year)
Cemetery or crematory: Mt Carmel
Location: Edmondson Ave
18. Funeral director: Wm J Connelly
Address: 1405 Eastern Ave
19. 1/29/ 19 47 (Date rec'd by registrar) John J Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27th 19 47, at 5A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 19 46, to Jan 26th 19 47
and that I last saw h[im] alive on Jan 23rd 19 47

Immediate cause of death	DURATION
Tuberculosis, pulmonary	3 yrs.
Due to: Cardiac failure	3 wks.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas B. Hayden, M.D.
M. D. or other
Address: 815 Eastern Ave Date signed: 1/28/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-25

2-0440 ——— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00325

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Baltimore

City or town: Riderwood

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 1420 W. Joppa Road

Stay in hospital or Inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Riderwood Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1420 W. Joppa Road

(If rural, give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME John Alexander Stuller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Helen C. Hooks

6(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): Sept 23. 1897

8. AGE:

Years	Months	Days	If less than one day
49	3	15	hrs. min.

9. Birthplace: Towsontown, Md.

(Town, county, and state)

10. Usual occupation: Clerk - Bookkeeper

11. Industry or business: Arundel Corp.

FATHER 12. Name: Harvey Stuller

13. Birthplace:

MOTHER 14. Maiden name: Annie Stuller

15. Birthplace:

16. Informant: Mrs. Helen C. Stuller

Address: 1420 W. Joppa Rd., Riderwood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 10, 1947 (month) (day) (year)

Cemetery or crematory: Prospect Hill Cem.

Location: Towson, Md.

18. Funeral director: John Burns' Sons

Address: Towson, Md.

19. Jan. 7 1947 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 7 1947, at 12:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19 , to 19 ,

and that I last saw h alive on 19

	DURATION
Immediate cause of death: Coronary occlusion	1/7/47
Due to: Chronic heart disease, type undetermined	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Rolling C. Hudson M.D. M.E.

M. D. or other

Address: Towson Md Date signed: 1/7/47

2-25

2-380- 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(93d) *00326 Reg. Dist. No. 4 X 0

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 132 days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hospital Fort Howard, Md.

How long in hospital or institution? 132 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Howard

City or town Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war WW I

3.(a) FULL NAME SAMUEL A. SWANN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife May S. Swann

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 3/25/85

8. AGE: Years	Months	Days	If less than one day
61	10	6	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name George F. Swann

13. Birthplace Richmond, Virginia

MOTHER 14. Maiden name Annie E. Llewellyn

15. Birthplace Richmond, Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 3 1947 (month) (day) (year)

Cemetery or crematory Baltimore National

Location Baltimore, Maryland

18. Funeral director Ellsworth Armacost

Address 3911 Liberty Heights Ave

19. 2-3 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 19 47 at 5:56 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 21st. 19 46, to January 31 19 47 and that I last saw him alive on January 31 19 47

Immediate cause of death	DURATION
CEREBRAL SOFTENING (LEFT TEMPORAL LOBE	Unknown
Due to CEREBRAL HEMORRHAGE	4 years
Due to	

Other conditions Arteriosclerotic Heart Disease
Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Substantiated as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

22. SIGNATURE H. L. Benaim M. D. or other

Address V. A. FORT HOWARD, MD. Date signed 2/1/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

6818 Sutter Ave.

Da 3658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 410

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Bair Creek
(c) Hospital or institution: Baltimore Co.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Bair #17 Balto N. Paul P.O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Annie May Tarbox

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 44 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Allen Hicks
13. Birthplace Ga.

MOTHER 14. Maiden Name Barry Hicks
15. Birthplace Ga.

16 (a) Informant William Birm.
(b) Address Bair Creek Balto Co Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Brooklyn Md

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley Ave

19 (a) 1/13/47 (Date rec'd by registrar) (b) W M Clearance

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8/47 19 , at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 - 1947, to Jan 8 1947, and that I last saw h[er] alive on Jan 8 - 1947.

Immediate cause of death	Duration
Lobar Pneumonia	6 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H P Thomas M. D.

Address 1000 Brantley Ave Date signed 1/13/47

V S 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

STATE OF MARYLAND—CERTIFICATE OF DEATH

00328

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

1. PLACE OF DEATH

County Baltimore Registration Dist. No. 4381

Village or City Towson No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where daath occurred 42 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Violet May Taylor

(a) Residence: No. 310 Lenox Ave St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
female	colored	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) NOV 10 1904

7. AGE	Yaars	Months	Days	If LESS than 1 day, hrs. or min.
	42	2	0	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. School teacher and postal clerk

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. U. S. Post Office

10. Date deceased last worked at this occupation (month and yaar) 10-22-43

11. Total tima (years) spent in this occupation Unknown

12. BIRTHPLACE (city or town) Towson (State or country) Md.

FATHER

13. NAME Alexander Taylor

14. BIRTHPLACE (city or town) Balto. Co. (State or country) Md.

MOTHER

15. MAIDEN NAME Mary Thomas

16. BIRTHPLACE (city or town) Balto. Co. (State or country) Md.

17. INFORMANT Corrine Taylor (Address) 310 Lenox Ave Towson Md

18. BURIAL, CREMATION, OR REMOVAL Place Pleasant Rest Date Jan 13th 1947

19. UNDERTAKER Bafzone Funeral Home (Address) 702 Pennsylvania Ave Baltimore Md

20. FILED Jan 17, 1947 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 1 (Month) 10 (Day) 1947 (Yaar)

22. I HEREBY CERTIFY, That I attended deceased from January 2, 1944, to 1-10, 1947

I last saw her alive on 1-9, 1947; death is said to have occurred on the date stetad above, at 2:30 a.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importanca were as tollows:

	Date of onset
Cerebal hemorrhage	10-24-43

Other **Contributory Causes** of importance:

Hypertension + arteriosclerosis	Unknown

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also tha following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Frank A. Saunders M. D.

(Address) 10 29 N. Stricker St.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other **contributory causes** of importance:	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other **contributory causes** of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

2-280-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00329 P

47c BC

64

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2531 Woodbrook Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war World War I ✓

3.(a) FULL NAME WILLIAM J. THOMAS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife Widowed

7. Birth date of deceased (mo., day, yr.) 5/12/1891 6.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
55-	7	25	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business

FATHER 12. Name William Thomas

13. Birthplace Prince George County, Md.

MOTHER 14. Maiden name Mary Carroll

15. Birthplace Howard County, Md.

16. Informant Clinical Records Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Date thereof Jan. 10/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bard's Memorial Cemetery

Location .....

18. Funeral director Mrs. Robert A. Elliott's Daughter

Address 1129 N. Caroline St

19. 1-9 1947 [signature] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 19 47, at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 20, 1946, to Jan. 7 1947

and that I last saw him alive on January 7 1947

Immediate cause of death	DURATION
CARCINOMA, BRONCHOGENIC	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert M. Cullison M. D. or other

Address V. A. H. FORT HOWARD, MD. Date signed 1/7/47

00330 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

CERTIFICATE OF DEATH

Reg. Dist. No. 4

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Balto-22
City or town Turners Station (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos
Hospital, institution, or street address where death occurred: 310 Wheeler Ct
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Balto
City or town Turners Station (If outside city or town limits, write RURAL and give nearest town)
Street No. 310 Wheeler Ct (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Christine Rosemary Thompson
3.(b) Social Security Number

4. Sex female
5. Color or race c
6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife none
none
6.(c) If alive, give age none years
7. Birth date of deceased (mo., day, yr.) Nov 2, 1946
8. AGE: Years 0 Months 1 Days 19 If less than one day none hrs. min.
9. Birthplace Balto, 22, Md (Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name George Thompson
13. Birthplace Balto- Md
MOTHER 14. Maiden name Coretha Murray
15. Birthplace Balto Md
16. Informant Coretha Thompson
Address 310 Wheeler Ct
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/21/47 (month) (day) (year)
Cemetery or crematory Mt. Calvary
Location A. A. County, Md.
18. Funeral director Joseph O. Locks, Jr.
Address 1304 N. Central Ave
19. 1-20 1947 [signature] (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19-47 19 , at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-19-47 19 , to 19
and that I last saw her alive on 2 mos ago 19

	DURATION
Immediate cause of death Probable asphyxia	
Due to smothering	
Due to accident	
Other conditions none	

(Include pregnancy within 3 months of death)
Major findings of operations none
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically. 49

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 1-19-47
Where did injury occur? Turners Station Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) home
Means of injury Smothered C. Injured at work? no

23. SIGNATURE Arthur [illegible] M. D. or other
Address 423 [illegible] Date signed 1-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

468 — 00331 — Reg. Dist. No. 381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore County
City or town: Towson, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 421 Jefferson Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary C. Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Eugene
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): February 22, 1890

8. AGE: Years	Months	Days	If less than one day
56			hrs. min.

9. Birthplace: Richmond, Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER — 12. Name: Unknown
13. Birthplace
MOTHER — 14. Maiden name: Unknown
15. Birthplace
16. Informant: Eugene Thompson
Address: 421 Jefferson Ave.
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan. 27, 1947 (month) (day) (year)
Cemetery or crematory: Pleasant Rest.
Location: Towson, Md.
18. Funeral director: Wm. George H. Hollan
Address: 1601 Druid Hill Ave.
19. Jan. 27 1947 (Date rec'd by registrar) A. W. Hebron Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 January 1947 at 5:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Jan. 1947 to 24 Jan 1947 and that I (last saw her) alive on 24 Jan. 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Dorton Folk M. D. or other
Address: 1506 Pennsylvania Ave. Date signed: 27 Jan. 47

Evidence for change of age is shown on Film D109-3120147-B.

00332

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore County

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Opitz Home, Edmonston & Nonunery Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Edmonston & Nonunery Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: RICHARD E. THORNE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 1869

8. AGE: Years	Months	Days	If less than one day
98 77			..... hrs. ..... min.

9. Birthplace: Friendly Pr. Geo. Co. Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: George W. Thorne
13. Birthplace: Md.

MOTHER
14. Maiden name: Roberta Taylor
15. Birthplace: Md.

16. Informant: Carlton E. Thorne

Address: 8101 Allentown Rd., Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 6th 1946 (month) (day) (year)

Cemetery or crematory: Providence M. E. Church Cemetery

Location: Friendly, Maryland

18. Funeral director: Thomas F. Murray

Address: 2007 Nichols Ave. SE.

19. Jan 6 1947 (Date rec'd by registrar) Harry W. Miller Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 4 1947 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Jan 4 1947 and that I last saw h alive on Jan 3 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 Days
Due to: Cerebral Arterio Sclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Catonsville Md. Date signed: 1-6-47

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d ★ 00333 Reg. Dist. No. 301

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 15 Belle Grove Road.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Thomas Tolson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Alice V. Tolson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 13, ~~1868~~ 1878

8. AGE: Years	Months	Days	If less than one day
68	4	23	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Stationary engineer
11. Industry or business
FATHER 12. Name: \ \ \
13. Birthplace
MOTHER 14. Maiden name: \ \ \
15. Birthplace
16. Informant: Mrs. Joseph Martin
Address: 15 Belle Grove Road-29
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 9, 1947 (month) (day) (year)
Cemetery or crematory: Western
Location: Baltimore, Md.
19. Funeral director: Ullrich Funeral Home
Address: 2008 Orleans St.,
19. 1-8 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 6, 19 47 at 1 P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 46 to January 6 19 47 and that I last saw h- alive on January 5 19 47

Immediate cause of death	DURATION
Acute Myocardial Failure	1 da.
Due to: Chr. Cardio-Vascular Disease	10 yr.
Due to:	
Other conditions: Ca of both lungs with metastases to retroperitoneal nodes	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wilmer K. Gallagher M.D.
M. D. or other
Address: Catonsville 28, Md. Date signed: 1-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13/a * 00334 P

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years, 3 months 8 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 5 years, 3 months, 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 320 South Franklintoen Road

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Louise Trommer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~Female~~ Female	White	Married

6.(b) Name of husband or wife: Frank Trommer

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): May 28, 1880

8. AGE:

Years	Months	Days	If less than one day
66	7	29	....hrs. ....min.

9. Birthplace: Alsace-Lorraine, France

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER

12. Name: Joseph Bueb

13. Birthplace: Alsace-Lorraine, France

MOTHER

14. Maiden name: Maria Ann (?)

15. Birthplace: Alsace Lorraine, France

16. Informant: Hospital records,

Address: Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/29/47 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Balto. Md.

18. Funeral director: Dill Bros.

Address: 3109 Frederick Ave.

19. Jan. 27 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26, 1947 at 8:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18, 1941 to January 26 1947 and that I last saw h... alive on January 26, 1947

Immediate cause of death	DURATION
Bronchopneumonia right lower lobe	48 hour
Due to: Post apoplectic condition	10 days
Due to: Hypertensive C-V-R disease	Indefinite
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Isadore Tuerk, M. D.

23. SIGNATURE: Isadore Tuerk, M. D. M. D. or other

Address: Catonsville, 28, Md. Date signed 1/26/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00335 300

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 8 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4700 Harford Road
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Isabella Troupe

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Jacob H. Troupe

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 7, 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79	7	22		

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Alexander Barnitz
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Isabella Whitmarsh
15. Birthplace: Baltimore, Maryland

16. Informant: Hospital records
Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/1/47 (month) (day) (year)

Cemetery or crematory: Green Mount

Location: Balto. Md.

18. Funeral director: William Cook, Inc.

Address: 1217 St. Paul St.

19. 1/31/47 (Date rec'd by registrar) D. W. Sadtler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29, 1947, at 8:10 pm

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 21, 1946, to January 29, 1947 and that I last saw her alive on January 29, 1947

Immediate cause of death	DURATION
Chronic arteriosclerotic coronary disease	indefinite
Due to Chronic myocardial infarction	2 months
Due to Chronic fibrous bilateral tuberculosis	indefinite
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed: 1-30-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. 00336

Balto.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5711 Gwynn Oak Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 5711 Gwynn Oak Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Talbott Trusler

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-0904

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lena S. Trusler

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 6, 1882

8. AGE: Years	Months	Days	If less than one day
64	8	1	hr. min.

9. Birthplace Indiana
(Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business

FATHER

12. Name Preston C. Trusler

13. Birthplace Indiana

MOTHER

14. Maiden Name Jessie Pumphrey

15. Birthplace Indiana

16 (a) Informant Mrs. Talbott Trusler

(b) Address 5711 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10, 1947 (month) (day) (year)

(c) Cemetery or crematory Crown Hill Cemetery

Location Indianapolis, Ind.

18 (a) Funeral director E. W. Shamoreau

(b) Address 4510 Liberty Heights Ave.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1947, at 2.40P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1946 to Jan 7 1947, and that I last saw him alive on Jan 5 1947

Immediate cause of death Coronary Thrombosis — Duration 1 hour

Due to Degenerative — 8 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. C. Brunk M. D.

Address 4509 Liberty Hgts Ave. Date signed

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 00337 41

1. PLACE OF DEATH:

County: Baltimore Co

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Mod Sanitarium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Sparrow Point

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2602 Dundalk Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bella Tscumbos

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife: Nicholas

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug - 18 - 1899

8. AGE: Years: 47 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Greece (Town, county, and state)

10. Usual occupation:

11. Industry or business: Laborer

FATHER 12. Name: Christopher Clucas

FATHER 13. Birthplace: Greece

MOTHER 14. Maiden name: Unk

MOTHER 15. Birthplace: Greece

16. Informant: Records

Address: Mod Sanitarium

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-29-47 (month) (day) (year)

Cemetery or crematory: Maryland Mem Pk

Location: Taylor Ave.

18. Funeral director: John F. Connelly

Address: 418 Eastern Blvd.

19. 1-28-47 (Date rec'd by registrar) 19 John F. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 25 1947 at 11 30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946 to Jan 25 1947 and that I last saw h alive on Jan 25 1947

Immediate cause of death	DURATION
Chr. Myocarditis	1 Mon
Due to: Myasthenia Gravis	3 Mon
Due to:	
Other conditions: Paralysis of Bladder	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: Catonsville Date signed 1-25

2-25

2-0440 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 83a

00338

Reg. Dist. No. 4 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1. PLACE OF DEATH:

County BALTIMORE

City or town FORT HOWARD, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 Days

Hospital, institution, or street address where death occurred:
VET. ADM. HOSP. FORT HOWARD, MARYLAND

How long in hospital or institution? 32 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County

City or town BALTIMORE
(If outside city or town limits, write RURAL and give nearest town)

Street No. 509 N. CARROLLTON AVE. BALTO. MD.
(If rural, give LOCATION)

2.(a) If veteran, name war WW I

3.(a) FULL NAME HARRY UPSHIRE

3.(b) Social Security Number 212-03-1541

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	NEGRO	MARRIED

6.(b) Name of husband or wife BESSIE UPSHIRE

6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 1/4/1888

8. AGE: Years	Months	Days	If less than one day
59		27	hrs. min.

9. Birthplace MIDDLESEX, VIRGINIA
(Town, county, and state)

10. Usual occupation LABORER

11. Industry or business

FATHER 12. Name UNKNOWN

13. Birthplace

MOTHER 14. Maiden name UNKNOWN

15. Birthplace

16. Informant CLINICAL RECORDS, VET. ADM. HOSP.

Address FORT HOWARD, MARYLAND

17. BURIAL Date thereof 2/5/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory BALTIMORE NATIONAL

Location BALTIMORE, MARYLAND

18. Funeral director MR. CHARLIE COOPER

Address 514 CARROLLTON AVENUE BALTIMORE, MD.

19. 2/5 19 47 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 31 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DECEMBER 30 19 46, to JANUARY 31 19 47 and that I last saw h...im...alive on JANUARY 31 19 47

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	38 days
Due to	
Due to	
Other conditions HYPERTENSION, ARTERIAL HEMIPLEGIA, LEFT (Include pregnancy within 3 months of death)	UNKNOWN 38 days

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison R.M.CULLISON, M.D., CLIN.DIR. M. D. or other

Address V.A.H.Fort Howard, Md. Date signed 1-31-47

Evidence for change of Age is shown on p 609 - 3/6/47

STATE OF MARYLAND—CERTIFICATE OF DEATH

00339 P

164c SS 220-12-7200

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

1. PLACE OF DEATH

County Baltimore — Registration Dist. No. 41

Village or City Dundalk 22, Pt. 3 No. 306 Glenhurst St., Pct. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. If of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME William H. Van Loon

(a) Residence: No. 306 Glenhurst Rd. St., Ward Md

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male.	White.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Maryann Van Loon

6. DATE OF BIRTH (month, day, and year) 1-13-1906

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
40			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Civil Service Asst

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. U. S.

10. Date deceased last worked at this occupation (month and year) ____

11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) (State or country) Penna

FATHER

13. NAME Wm. Fletcher Van Loon Md

14. BIRTHPLACE (city or town) (State or country) Penna

MOTHER

15. MAIDEN NAME —

16. BIRTHPLACE (city or town) (State or country) —

17. INFORMANT Mary Rotzenwicke (Address) Dundalk Md

18. BURIAL, CREMATION, OR REMOVAL

Place Penna Date Jan 9, 1947

Funeral Director

19. UNDERTAKER Henry Brueckmann (Address) 1409 Eastlawn Rd

20. FILED 1-9-1947 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (Month) Jan (Day) 8, 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1947, to Jan 8, 1947,

I last saw him alive on ____, 19____; death is said to have occurred on the date stated above, at ____ m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Compound fracture skull	Immediate
Shot with 30-30 Rifle	
thru rt. temple	
Other **Contributory Causes** of importance:	
Evisc. top head	
Blown off.	

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following: Suicide

Accident, suicide, or homicide? Suicide Date of injury 1/6, 1947

Where did injury occur? At Home (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. Home

Manner of injury Hunting Rifle 30-30.

Nature of injury Bullet wound.

24. Was disease or injury in any way related to occupation of deceased? ____

If so, specify ____

(Signed) H. McGuinness M. D.

(Address) Deputy Medical Examiner

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1. Co. Dundalk Md

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home.** For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, **e. g.,** heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

State

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1637

Registered No. 00340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address White Marsh, Maryland.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 N. Montford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS GODFREY VOTTA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 - 3 - 08

8. AGE: Years 38 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John L. Votta
13. Birthplace Baltimore

MOTHER
14. Maiden Name Betty Biebert
15. Birthplace Baltimore

16 (a) Informant E. Votta, Wife
(b) Address 20 N. Monford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-47 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location O'Donnell St.

18 (a) Funeral director Lillge Zeiler Inc
(b) Address 403 S. Wolfe Street

19 (a) 1-15-47 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1947, at 4 p. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carbon Monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-8-47 at approx. 2 p. M.
(b) Where did injury occur? Gravel Pit-White Marsh, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Automobile exhaust

23. Signature Geo. G. Merrill M.D.
Medical Examiner.
Date signed 1-9-47

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00341

Reg. Dist. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3002 Taylor Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lena Wagner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 23rd, 1868

8. AGE:

Years	Months	Days	If less than one day
79	3	5	hrs. ..... min.

9. Birthplace: Georgetown, Washington D.C.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: at home

FATHER
12. Name: Henry Wagner
13. Birthplace: Europe

MOTHER
14. Maiden name: Elizabeth England
15. Birthplace: Maryland

16. Informant: Mrs. Mamie ~~Benton~~ Burton

Address: 3002 Taylor Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30, 1947 (day) (year)

Cemetery or crematory: St. Johns Lutheran Cemetery

Location: Parkville, Md.

18. Funeral director: Lanahan Funeral Home

Address: 7401 Belair Road

19. Jan 29 1947 (Date rec'd by registrar) Mrs. G. L. Rupknudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28th 1947 at 12:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sun. Jan 26 1947 to Jan. 27 1947 and that I last saw her alive on Mon. Jan 27 1947

Immediate cause of death	DURATION
Coronary Thrombosis	5 days
Due to ~~5 days~~	
Due to Generalized arterio-sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Harold A. Gatt, M.D.
M. D. or other

Address: 4100 Harford Rd. Date signed 1/29/47

Dr Pratt
8100 Hartford Rd

00342 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Old Frederick Rd. & Nunnery Lane
How long in hospital or institution? 30 yrs. in Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Old Frederick Rd. & Nunnery Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James R. Walsh

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married

6.(b) Name of husband or wife: Colette Walsh
nee Wess
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 25, 1887

8. AGE: Years	Months	Days	If less than one day
59	9	26	..... hrs. ..... min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: Restaurant owner
11. Industry or business: Walsh
FATHER 12. Name —
13. Birthplace —
MOTHER 14. Maiden name —
15. Birthplace —
16. Informant: Mrs. Colette Walsh
Address: Old Frederick Rd. & Nunnery Lane
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 24/47 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: 4300 Old Frederick Rd.
18. Funeral director: Harry H. Nitzke
Address: 4101 Edmondson Ave.
19. 1/22 47 H. L. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 21/47 19..... at 3.40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. (19 46 to Jan 21 19 47
and that I last saw h... alive on Jan 21 19 47

Immediate cause of death	DURATION
Cor. Myocardit's	2 mos.
Due to Cirrhosis of Liver	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Catonsville Date signed 1-22

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a 00343

Reg. Dist. No. 241

1. PLACE OF DEATH:
County Balto.
City or town Edgemere
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Edgemere, Lodge Forest
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2106 Oak Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edgar Enoch Halter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married

6.(b) Name of husband or wife Hazel E. Halter
nee Great 6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Nov. 3 - 1900

8. AGE:

Years	Months	Days	If less than one day
46	2	2	..... hrs. ..... min.

9. Birthplace Middletown, Va.
(Town, county, and state)
10. Usual occupation manager
11. Industry or business Moving Picture Parlor
FATHER 12. Name Robert C. Halter
13. Birthplace Va.
MOTHER 14. Maiden name Mary E. Cake
15. Birthplace Va.
16. Informant Mrs. Hazel Halter
Address 2106 Oak Rd. Lodge Forest
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 8-1947 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.
18. Funeral director John E. Connelly
Address 418 Eastern Ave. Essex
19. Jan. 7 - 1947 John E. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 - 1947, at 5 00 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Coronary Occlusion	5 m.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D., or other
Address Dundalk, Md. Date signed 1-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25 2-40-1-10

1-25

2-440-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00344

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County 426 Virginia Avenue
City or town Towson Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 426 Virginia Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Guy Wilson Hattrick

3.(b) Social Security Number 212-10-9681

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Elizabeth M. Hattrick
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 21-1875

8. AGE: Years 71 | Months 1 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Chambersburg Pennsylvania (Town, county, and state)
10. Usual occupation Machinist
11. Industry or business Retired 5 years

FATHER
12. Name Jerry Hattrick
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Mrs. J. Lawrence Taylor
Address 1319 N. 40th Street Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 3 1947 (month) (day) (year)
Cemetery or crematory Cedar Grove
Location Chambersburg Pennsylvania

18. Funeral director Burgee Funeral Home
Address 3631 Falls Road, Baltimore

19. 2/1 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31- 1947 at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25th 1947 to Jan 31st 1947 and that I last saw h.. alive on Jan 31st 1947 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 week
Due to Geneske arteriosclerosis	
Due to	
Other conditions Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Daniel J. St. Thos. Jenkins M. D. or other
Address Towson 4, Md. Date signed 2/4/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd 2/1/47

Dr. Jenifer
111 Allegheny Ave.
Towson 3

00345

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 27 days
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 1 month, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Ellicott City (If outside city or town limits, write RURAL and give nearest town)
Street No.: Ellicott St (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Samuel Watkins
3. (b) Social Security Number:

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Clara Blanche
6.(c) If alive, give age: 70 years
7. Birth date of deceased (mo., day, yr.): July 10, 1870

8. AGE:	Years	Months	Days	If less than one day
	76	6	12	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired operator
11. Industry or business: Telegraph
FATHER 12. Name: John Beale Watkins
13. Birthplace: Maryland
MOTHER 14. Maiden name: Clara Augusta Bagley
15. Birthplace: Maryland
16. Informant: Hospital records
Address: Catonsville-28, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-25-47 (month) (day) (year)
Cemetery or crematory: Fork
Location: Fork Md.
18. Funeral director: F.C. Higinbotham
Address: Ellicott City Md.
19. 1-23 1947 (Date rec'd by registrar) Harry [illegible] (deputy) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 1947 at 6:40 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...
and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death: Acute Cardiac failure	
Due to:	
Due to: Cardiovascular disease	
Other conditions: sudden death	
Injury (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.
Autopsy results: As Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. [illegible] Kieffer M. D. or other — Dep. Med. Exam. [illegible]
Address: 1010 Leeds ave Date signed: 1-22-47

1-35

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00346

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Rossville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Rossville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3 or 4 3 2 9 Lemming Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hattie Wayland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Robert B. Wayland
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 10 - 1880

8. AGE:

Years	Months	Days	If less than one day
66	6	28	..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name ? Kirby
13. Birthplace Va.

MOTHER
14. Maiden name Unknown
15. Birthplace "

18. Informant Robert B. Wayland
Address 3 or 4 3 2 9 Lemming Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 11 - 47 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.
18. Funeral director John J. Connelly
Address 418 Eastern Ave. Essex

19. Jan 11 1947 John J. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Jan 1947, at 4 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 Dec. 1946 to 8 Jan 1947
and that I last saw h... alive on 8 Jan 1947

Immediate cause of death	DURATION
Gastric Hemorrhage	1 hour
Due to Gastric neoplasm	
Due to	
Other conditions Diabetes mellitus 5 yrs. Arteriosclerotic C. Vdisease	

(Include pregnancy within 3 months of death)

Major findings of operation Lipomata of undiagnosed site Pulmonary Tuberculosis
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. L. Kolodny M. D. or other
Address 45 Edgevale Apt 18 Date signed 1/8/47
Balt. 21

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-440-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00347

CERTIFICATE OF DEATH

Reg. Dist. No. 38 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information, carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since November 17, 1946

Hospital, Institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since November 17, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ~~Washington~~ Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 Walnut Place
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Sheila Kay White

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7, 1946

8. AGE: Years: 9 Months: 2 Days: If less than one day: 8 hrs. 40 min.

9. Birthplace: Cumberland Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Allen White
13. Birthplace: Maryland

MOTHER
14. Maiden name: Irene Domm
15. Birthplace: Maryland

16. Informant: Personal History-Hospital Records
Address: Eudowood Sanatorium, Towson 4, Md.

17. Removal
(Burial, cremation, or removal. Which?) Date thereof: 1/10/47 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cmty

Location: Cumberland, Md.

18. Funeral director: Chas L. Cook, Inc.

Address: 12 W St Paul St Baltimore Md

19. Jan 9 1947 W. Carroll Seyfert Registrar
(Date rec'd by registrar) Deputy Health Officer

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 9 1947 at 8 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 1946 to Jan. 9 1947 and that I last saw h[illegible] alive on Jan. 8 1947

	DURATION
Immediate cause of death: Miliary Tuberculosis	Unknown found by X-ray Chest Oct 1946
Due to:	
Due to:	
Other conditions: Meningitis, Tuberculous	about 1 month

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. A. Bridges M.D. Supt
M. D. or other

Address: Towson 4, Maryland Date signed:

2-25

2-380-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00348 8

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
6500 Dogwood Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6500 Dogwood Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Joseph Widerman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Myrtle A. Widerman

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): August 1, 1889

8. AGE: Years	Months	Days	If less than one day
57	5	13	...hrs. ...min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual occupation: Truckman

11. Industry or business: Self

FATHER
12. Name: David Widerman
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden name: Caroline Uhler
15. Birthplace: Baltimore County, Md.

16. Informant: Mrs. Myrtle A. Widerman
Address: 6500 Dogwood Rd., Woodlawn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 17, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Olive Cemetery

Location: Randallstown, Md.

18. Funeral director: Hellen Lamoreau

Address: 4510 Liberty Heights Ave.

19. 1-16-47 (Date rec'd by registrar) 19... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 14 1947, at 10.40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 26 1946, to 1/14/47 19...
and that I last saw him alive on 1/13/47 19...

Immediate cause of death	DURATION
Cerebral Hemorrhage	
and paralysis	3 days
Due to: Hypertension	?
Due to: Arteria Sclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Walter S. Riblett M. D., or other

Address: 2220 Garrison Blvd. Date signed: 1/16/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00349

CERTIFICATE OF DEATH

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 32 Sacred Heart Lane
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Rosa Ella Williams

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 4, 1890

8. AGE: Years	Months	Days	If less than one day
56	1		hrs. min.

9. Birthplace: Carroll Co.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: John Williams

FATHER 13. Birthplace: Balto. Co.

MOTHER 14. Maiden name: Cassanda Nelson

MOTHER 15. Birthplace: Balto. Co.

16. Informant: Emma Williams

Address: Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 7, 1947 (month) (day) (year)

Cemetery or crematory: Piney Grove

Location: Balto. Co.

18. Funeral director: J. F. Eline & Sons

Address: Reisterstown, Md.

19. Jan 7 1947 (Date rec'd by registrar) Dary B. Eline, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 4 19 47, at 5:32 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-20 19 46, to 12-27 19 46 and that I last saw h[er] alive on [illegible] was alive 1-4 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	5 minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dr D D Eagles Med. Exam. M. D. or other

Address: Reisterstown, Md. Date signed: 1-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00350

CERTIFICATE OF DEATH

Reg. Dist. No. 4 b

1. PLACE OF DEATH:

County: Baltimore

City or town: Notch Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Notch Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sister Mary Adolorata Wilson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 4, 1900

8. AGE: Years: 46 | Months: 8 | Days: 28 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: John Wilson
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Hyacinth Manning
15. Birthplace: Baltimore

16. Informant: Sr. Mary Clara

Address: Notch Cliff

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 4th 1947 (month) (day) (year)

Cemetery or crematory: Notch Cliff

Location: Glen Ayre

18. Funeral director: Geo M. Fink & Son

Address: 611 D Wolpert

19. 1/2/47 (Date rec'd by registrar) 19.. Watts A. Hamill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2 19 47 at 6.20 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..

and that I last saw her alive on Dec. 30 19 46

	DURATION
Immediate cause of death: Cardiac Failure	10 days
Due to: Uremia	2 weeks
Due to: Eclampsia obesity	
from generalized	
Other conditions: glandular	
Malfunction	20yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles K Powell MD
M. D. or other

Address: 30 York Rd Towson Date signed 1/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

8

00351

932

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Baltimore County
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred: 6730 Windsor Mill Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore Co
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6730 Windsor Mill Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Pius Wokeitaitis

3.(b) Social Security Number

4. Sex: male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Margaret Wokeitaitis
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept 8 1873

8. AGE: Years 73 Months 4 Days 7 If less than one day ... hrs. ... min.

9. Birthplace: Lithuania
(Town, county, and state)
10. Usual occupation: Coal miner (retired)
11. Industry or business: Hard coal mine (Penna)

FATHER
12. Name: ? Wokeitaitis
13. Birthplace: Lithuania

MOTHER
14. Maiden name: ?
15. Birthplace: Lithuania

16. Informant: Mrs H. E. Boyd
Address: 6730 Windsor Mill Rd

17. Burial Date thereof: 1-20 47
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory: St Georges
Location: Shenandoah Pa.

18. Funeral director: Charles W Zachariasber
Address: 703 McHenry St Balto 30 Md

19. Jan 17 1947 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1947, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1941, to Jan 15 1947
and that I last saw him alive on Dec 27 1946

Immediate cause of death	DURATION
Chronic Myocardial Degeneration	10 yrs
Due to Senility	
Due to	
Other conditions: Silicosis, Chronic Bronchitis, Chronic Emphyzema	uncertain

(Include pregnancy within 3 months of death)

Major findings of operations: no operation
Date of op.
Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Joshua H. Armacost MD
M. D. or other
Address: 6419 Windsor Mill Rd Baltimore-7
Date signed: Jan 16 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00352

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since January 10, 1945

Hospital, Institution, or street address where death occurred: Fudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since January 10, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

Street No. 45 Wade Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Catherine Thelma Wolfe

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Willard N Wolfe

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 1, 1915

8. AGE: Years: 31 Months: 6 Days: 11 If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore County, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Charles Gregory

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lillian Yowell

15. Birthplace: Unknown

16. Informant: Personal History- Hospital Records

Address: Fudowood Sanatorium, Towson 4, Md.

17. (Burial, cremation, or removal. Which?) Burial — Date thereof: 1/15/47 (month) (day) (year)

Cemetery or crematory: Mountland Park

Location: Parkville Md.

18. Funeral director: William Cook Inc.

Address: 217 St. Paul St

19. (Date received by registrar) 1/14 19 47 — D. W. Hedrick — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12 19 47, at 5 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1945, to Jan 12 1947 and that I last saw her alive on Jan 11 1947

Immediate cause of death	DURATION
Pulmonary tuberculosis	Since July 1943
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W A Bridges M. D. or other

Address: Towson 4, Maryland Date signed: .....

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92 c BC

00353

Reg. Dist. No. 44

8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 hrs. 55 mins.
Hospital, Institution, or street address where death occurred:
Veterans Administration Hospital
How long in hospital or institution? 13 hrs. 55 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1722 Aliceanna Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War

3.(a) FULL NAME: WUESTNER, Christian L.

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian Wuestner
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): March 29, 1896

8. AGE: Years	Months	Days	If less than one day
50	10	1	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Clerk at race track
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace:
MOTHER 14. Maiden name: Mary Stump
15. Birthplace: Maryland
16. Informant: Clinical Records, Veterans Administration Hosp., Fort Howard, Md.
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/3/47 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Taylor Ave
18. Funeral director: Lilly & Zeiler
Address: 403 S. Wolfe St. Balto. Md.
19. 1/31 1947 (Date rec'd by registrar) A. G. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 19 47 at 1:25 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 29 19 47, to January 30 19 47 and that I last saw him alive on January 30 19 47

Immediate cause of death	DURATION
Heart failure	
Due to: Rheumatic endocarditis with stenosis of mitral valve and insufficiency of aortic valve	8 years
Due to:	
Other conditions: Pulmonary infacts, lobular pneumonia	2 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Substantiated above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison M.D.
R. M. CULLISON, M.D. CLINICAL DIRECTOR
Address: VAH, Fort Howard, Md. Date signed: 1/30/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

00354

Reg. Dist. No. 23

P

1. PLACE OF DEATH:
County: Baltimore
City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 113 Raspe Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Wuestner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lizzie Wuestner
6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): Dec 8th 1859

8. AGE: Years: 88 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Tinner

11. Industry or business

FATHER
12. Name: Michael Wuestner
13. Birthplace: Germany

MOTHER
14. Maiden name: Dont Know
15. Birthplace: Germany

16. Informant: Lizzie Wuestner
Address: 113 Raspe Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 23 1947 (month) (day) (year)
Cemetery or crematory: Moreland Memo Park
Location: Rural

18. Funeral director: Ulrich Funeral Home
Address: 2008 Orleans St

19. Jan 21 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20th 1947 at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1946 to Jan 20 1947 and that I last saw him alive on Jan 15 1947

Immediate cause of death	DURATION
(a) Myocarditis	2 yrs
Due to: Arteriosclerosis	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H Hardwig M. D. or other
Address: 4810 Belair Rd Date signed: Jan 24 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

57 B 00355

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Balto.
City or town: Cwings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto.
City or town: Cwings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Reisterstown & Kinsley Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Wesley Zepp

3.(b) Social Security Number: 216-07-8163

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Margaret E. Zepp
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 11, 1872

8. AGE: Years	Months	Days	If less than one day
74	7	7	hrs. min.

9. Birthplace: Carroll Co.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Absalom Zepp
13. Birthplace: Unknown

MOTHER
14. Maiden name: Margaret
15. Birthplace: Unknown

16. Informant: Joseph Zepp
Address: Cwings Mills

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 21, 1947 (month) (day) (year)
Cemetery or crematory: Grace Methodist
Location: Balto. Co.

18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.

19. 1-21-1947 (Date rec'd by registrar) Mary B. Eline. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18 1947 at 1 30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-10 1946, to 1-18 1947 and that I last saw h-im alive on 1-16-47 19

Immediate cause of death	DURATION
Arteriosclerosis	1 yr.
arthritis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: D. D. Eagles, M.D.
M. D. or other
Address: Reisterstown, Md. Date signed: 1-18-47

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35